A COMPARATIVE SURVEY OF MEDICAID HOSPITAL REIMBURSEMENT SYSTEMS FOR INPATIENT SERVICES, STATE BY STATE, 1980-1985

Information
Resource
Center
IHPP
2

INTERGOVERNMENTAL HEALTH POLICY PROJECT
George Washington University

REPORTS
RA
971
.3
L38
1986
IHPP

Intergovernmental Health Policy Project
George Washington University

The Intergovernmental Health Policy Project serves a unique function in the development of the nation's health policy. It is the only university-based program in the country concentrating its research efforts exclusively on the health laws and programs of the 50 states. The Project provides assistance to state executive officials, legislators, legislative staff and others who need to know about important developments in other states. At the same time, the IHPP helps federal officials identify innovative state health programs and specific state problems.

To facilitate these informationbrokering activities, the IHPP maintains direct links with state governmental agencies, state legislatures, research centers, planning agencies, and interest groups throughout the country. Reliable, up-to-date information on health legislation and programs is obtained through IHPP's own network of knowledgeable health policy experts in each of the 50 states, as well as from its clearinghouse of all state health legislation.

Through its newsletter, *State Health Notes*, research publications, and conferences, the IHPP provides key health policymakers with timely, comprehensive examinations of innovative state legislative activities and health programs.

The Intergovernmental Health Policy Project is affiliated with the National Health Policy Forum, with which it works closely to identify issues of concern to state and federal policymakers. The National Health Policy Forum is a privately funded non-profit organization which provides in-service educational experiences to high level congressional, White House and executive agency specialists in health care. Both the IHPP and the Health Policy Forum operate under the auspices of The George Washington University in Washington, D.C.

The programs and the services of the Intergovernmental Health Policy Project are made possible through a contract from the Office of Intergovernmental Affairs, Health Care Financing Administration, Department of Health and Human Services (HCFA Contract #500-86-0009). Milton Dezube is the project officer.

The Intergovernmental Health Policy Project
2100 Pennsylvania Avenue, Northwest, Suite 616
Washington, D.C. 20037
(202) 872-1445

RA
971.3
.L38
1986

A COMPARATIVE SURVEY OF MEDICAID HOSPITAL REIMBURSEMENT SYSTEMS FOR INPATIENT SERVICES, STATE BY STATE, 1980-1985

by

Susan S. Laudicina
The Urban Institute

December 1985

in association with the
Intergovernmental Health Policy Project
George Washington University

Available from:

Intergovernmental Health Policy Project
2100 Pennsylvania Avenue, N.W.
Suite 616
Washington, D.C. 20037

List price: $15.00 (includes shipping and handling)

Copyright © 1986, The Urban Institute, in association with Intergovernmental Health Policy Project, George Washington University.

This document may not be reproduced without the permission of the author.

PREFACE

The research for this report was supported by a grant from the Robert Wood Johnson Foundation. It is part of a larger Johnson project which will examine the root causes behind the recent deceleration in U.S. hospital expenditures. It is our hope that this survey will be a useful resource to government policymakers and analysts, and will contribute to an improved understanding of the nature of Medicaid cost containment strategies.

The compilation and analysis of the data in this survey was done by Susan S. Laudicina, consultant to The Urban Institute. Much of the data related to state Medicaid hospital reimbursement programs was furnished by the Health Care Financing Administration and the Intergovernmental Health Policy Project. We are grateful to all of the HCFA staff members, both in the central and the regional offices, who lent their time and assistance to clarify the intricacies of state Medicaid laws and regulations. We also appreciate the contribution and assistance of Richard E. Merritt, Director of the IHPP, in sharing information and supporting the publication of this document.

Other individuals also made important contributions to this report. Stephen Zuckerman of The Urban Institute provided essential editing assistance. Marianna Diggs and Joan Sanders provided excellent secretarial and production assistance in preparing numerous drafts of this report.

John Holahan
Director
Health Policy Center
The Urban Institute

OVERVIEW

The five-year period since 1980 has witnessed a sweeping reversal of priorities and strategies in the administration of public health insurance programs in the United States. This fifty-state survey compares in detail the evolution of Medicaid and other reimbursement systems for inpatient hospital services.

Looking at 1980, one is most struck by the dominant influence of the Medicare program on payment for hospital services for low-income Medicaid patients. Forty states employed Medicare retrospective cost-based principles as the standard for their Medicaid programs. Just three years later, in January 1983, the number had dwindled to 25; and by June of 1985 the total had declined to the point where today only 14 states allow Medicare principles to govern payment for inpatient hospital services under their Medicaid programs. Moreover, the number will certainly fall further, as several of these states have expressed the intention to adopt alternative reimbursement systems.

In dollar terms, this evolution is quite striking. At the start of federal fiscal year 1980, Medicaid expenditures for inpatient general hospital services in states with alternative payment schemes represented just 38 percent of total Medicaid expenditures nationwide. By the end of fiscal year 1984, this amount had grown to 90 percent of the total.

Table 1 illustrates this phenomenon in comparative terms. While retrospective payment systems prevailed in 41 states at the beginning of 1980, the reverse is true today: prospective payment is practiced under Medicaid in 34 states.

The prospective reimbursement system that has experienced the greatest increase is one which applies simple rate of increase controls to allowable

Table 1

Evolution of Medicaid Inpatient
Hospital Reimbursement Systems

Type of System[1]	January 1980	January 1983	June 1985
A) Medicare Retrospective Cost-Based Principles	40 states	25 states	14 states
B) Prospective Budget Review	5 states	3 states	2 states[2]
C) Prospective Rate of Increase Controls	5 states	15 states	23 states
-- (with peer group cost ceilings)	(3)	(8)	(10)
D) Retrospective Rate of Increase Controls[3]	1 state	4 states	4 states
E) Prospective Case Mix System	2 states	2 states	7 states
F) Negotiation/Contracting	1 state	3 states	5 states

[1]Does not add to 50 states plus District of Columbia because some states employ different systems for different hospitals.

[2]Budget review can be performed in Maryland and New Jersey in response to a provider's appeal of its rate; this contingency arises only infrequently.

[3]This system differs from category "C" system in that it makes an end-of-year final settlement.

base year costs. In addition, two other systems have developed widely in the past five years: negotiation or fixed contracting schemes, and prospective case mix systems. The latter provides an example of a model which enjoys growing popularity. At present, seven states use a case mix payment system based on diagnostic-related groupings (DRGs) or a state-developed classification scheme of illness categories; and several more will adopt one within the coming year.

These local trends are paralleled closely by several national developments in hospital reimbursement. During the period from 1980 to 1982, Congress enacted the following legislation: (1) reductions to the rate of increase in federal payments to Medicaid; and (2) the Omnibus Budget Reconciliation Act of 1981 (OBRA) which greatly enhanced the ability of states to digress from traditional Medicare retrospective payment practices. These measures were followed by a second period of Congressional activity reforming the Medicare program itself: (1) the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) mandated stricter, more comprehensive limits to reimbursement for inpatient hospital services; and (2) the adoption of the Medicare Prospective Payment System (PPS) in 1983 employing DRGs to determine prospective case per discharge amounts. All of these steps have contributed to the economic and political pressures on states to adopt alternative hospital reimbursement strategies in their Medicaid programs.

Turning to Table 2, one sees how states have responded to these incentives in terms of adopting new units of payment designed to promote the more cost-conscious delivery of inpatient hospital services. Clearly, the retrospective per diem has become a vanishing species: once in use in 40 states, now only found in 14. The most frequently employed payment units are the

Table 2

Evolution of Medicaid Inpatient
Hospital Reimbursement Systems

Unit of Payment[1]	January 1980	January 1983	June 1985
A) Retrospective Per Diem	40 states	26 states	14 states
B) Prospective Per Diem	7 states	14 states	21 states
C) Retrospective Per Case	1 states	4 states	4 states
D) Prospective Per Case	2 states	4 states	13 states
E) Global (percentage of charges) or Other	2 states	5 states	5 states

[1]Does not add to 50 states plus District of Columbia because some states employ different systems for different hospitals.

prospective per diem and some form of prospective per case rate, either on a simple per admission basis or a discharge diagnosis basis.

As one considers the nature of the growth in prospective or other alternative payment programs under Medicaid, one is struck by their growing sophistication and technical competence. Special provisions designed to correct the perceived shortcomings of earlier, more simplistic systems have become the norm, as highlighted in Table 3. For instance, payment rates are currently adjusted for the impact of inflation in 34 programs, virtually every alternative state. Complex adjustments for changes in volume as well as changes in projected case mix intensity are now common in a number of states which do not adhere to traditional Medicare cost principles. In addition, 24 state Medicaid programs have developed special adjustments which recognize costs associated with the provision of uncompensated care which undermines the financial stability of facilities.

Finally, this comparative analysis examines the growth of alternatives to retrospective hospital reimbursement for other payers in addition to Medicaid. In particular, the presence of all-payer systems has been a familiar landmark in the health delivery system since at least 1980. Their numbers have remained steady at three or four, with the exact composition of states varying from time to time. However, within the coming year there could be a jump in their size from the current four (Maryland, Massachusetts, New Jersey, and New York) to a total of seven or eight (with the addition of Connecticut, Maine, Washington, and West Virginia). Each of the latter states has expressed the intention of applying for federal Medicare and Medicaid waivers to add these payers to their ongoing systems.

Table 3

Special Provisions of Medicaid Alternative Inpatient Hospital Reimbursement Systems

Program Mechanism	January 1980	January 1983	June 1985
A) Inflation Adjustment	8 states	23 states	34 states
B) Volume Adjustment	8 states	13 states	13 states
C) Case Mix Adjustment	2 states	8 states	12 states
D) Uncompensated Care Adjustment	2 states	14 states	24 states
E) Occupancy Adjustment	2 states	5 states	8 states

Organization of State Medicaid Tables

The following 51 tables are arranged alphabetically, and provide a detailed breakdown of each state Medicaid agency's hospital reimbursement practices for inpatient services over the period January 1980 to June 1985. In those states with a Medicaid alternative payment scheme, federal regulations require that final aggregate payments to hospitals do not exceed the amount that would have been paid under Medicare principles of provider reimbursement in effect at the time, or the level of a provider's customary charges.

In the column labeled "Adjustments," all significant adjustments to a hospital's payment rate allowed under a state Medicaid agency's rules are set forth. Excluded are minor adjustments or exceptions based on such variables as mechanical errors in cost report data, costs associated with certificate-of-need-approved alterations, costs associated with the carrying out of federal regulations in general, e.g., life and safety codes, and costs arising from circumstances beyond a provider's control.

Under the column heading "Payers Included," the total number of hospitals in each state which are covered by the alternative reimbursement system is indicated. For the most part, these participating facilities are limited to short-term, acute-care community hospitals. In a few states, other providers such as psychiatric institutions may be covered also.

The last column is entitled "Utilization Controls." It describes existing state Medicaid regulations which, while generally not a part of the reimbursement program per se, could impact significantly upon the level of payment received by hospitals.

ABBREVIATIONS

ALOS	Average Length of Stay
BLS	Bureau of Labor Statistics
CON	Certificate of Need
CPI	Consumer Price Index
DRG	Diagnostic-Related Groupings
DRI	Data Resources, Inc.
EPSDT	Early and Periodic Screening, Diagnosis and Treatment Program; required for minors under Medicaid
HAS	Hospital Administrative Services - Special Group Report
PAS	Professional Activities Study
PPI	Producer Price Index
PSRO/PRO	Professional Standards Review Organizations; reorganized as Peer Review Organizations
SMSA	Standard Metropolitan Statistical Area
WPI	Wholesale Price Index

PROFILES OF STATE MEDICAID INPATIENT HOSPITAL REIMBURSEMENT SYSTEMS

MEDICAID INPATIENT HOSPITAL REIMBURSEMENT SYSTEMS

ALABAMA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles	Medicaid					Limit of 15 days per calendar year, unless extension authorized.
1981							No weekend admissions except emergencies.
1982 [Effec. 10/1/82]	Mandatory, prospective reimbursement system. Applies rate of increase control in conjunction with hospital peer group ceilings.	Medicaid 131 hospitals	Per diem	Prospective per diem based on prior year cost report is trended forward each July 1 as follows: --Base year rate is multiplied by hospital industry trend factor using DRI Natl. Market Basket adjusted for Ala. inflation; --If difference between projected and actual trend factor is >.05%, an adjustment is made; --This per diem amount used to calculate cost ceiling of 1/2 Standard Deviation [SD] from mean for hospital's peer group; --Hospitals divided into 4 urban and 4 rural cells based on bed size; --New per diem rate is lower of cost per day or class ceiling. Cannot exceed Medicare limits.	Based on Medicare, includes: routine operating costs ancillary services costs capital education Excludes: routine nursing differential	Uncompensated Care Relief provided if hospital's Medicaid utilization rate is >1 SD above mean rate of all state providers, and original per diem exceeds group ceiling. Hospitals received lesser of its original per diem OR a factor of .05% for each .1% its Medicaid utilization rate >1 SD above mean rate, applied to its group ceiling rate. Case Mix No explicit adj. is made.	Medicaid Agency does not recognize any costs resulting from a CON dated on or after 10/1/83. Prior authorization required for certain specific procedures.

ALABAMA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1983 [Effec. 10/1/83]						Low Occupancy Minimum occupancy rate of 70% is required for hospitals with 100 or fewer beds; 80% for hospitals with 100 or more beds. Reduction in Medicaid inpatient costs is computed based on fixed cost associated with excess unoccupied beds.	Reduced limit to 12 patient days per year.
1984 [Effec. 1/1/84]	Reimbursed hospitals at lesser of customary charges or reasonable cost per day, as defined above.						Payment denied for services rendered at inappropriate level of care, i.e., will not pay hospital per diem if patient can be treated at SNF level. 12-day limit can be extended for EPSDT individuals under 21.
1985	No change.						

ALASKA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					
1981	No change						
1982							Prior authorization required for certain specific procedures. Limit of 21 days per year.
1983 [Effec. 10/1/83]	Mandatory, prospective reimbursement system. Applies rate of increase controls. No peer group ceilings are used.	Medicaid 16 hospitals	Percentage of charges	Prospective payment rates expressed as percentage of charges set as follows: --Base year is hospital's prior fiscal year; rate year is FY beginning on or after 10/1/83; --Payment equal to most recent rate in prior year, adjusted by 8% inflation factor; --Limits can't exceed what would be paid under Medicare TEFRA limits or provider's customary charges.	Based on Medicare; excludes routine nursing differential	No retroactive adjustments allowed for inflation, volume, occupancy or case mix.	Prior authorization required for all non-emergency admissions. Removed 21-day limit.

ALASKA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1984	New plan to be effective 7/1/84 or later has been submitted; not yet approved by HCFA.	Medicaid	Not available	Not available	Total financial requirements: operating costs education bad debts charity care profit factor	Would allow volume adjustments thru application of corridor system.	
1985	No change						

ARIZONA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	No Medicaid program exists; county governments responsible for indigent care.						
	Mandatory budget review, but voluntary compliance.	Blue Cross Commercial Payers Self-Pay	Charges	Reviews proposed rate changes; no statewide guidelines or methodology exist for evaluating proposed increases. Public disclosure of unfavorable findings.			
1981	No change						
1982 [Effec. 10/1/82]	Implemented state-wide demonstration under Medicaid waiver authority. Under the Arizona Health Care Cost Containment System, state contracts with provider groups in competitive bidding process to serve enrollees within specific local areas.	Medicaid State/ county employees 59 hospitals	Fixed, capitated amount per enrollee	Prospective payment system pays contractors fixed, monthly capitated dollar amount to cover costs of comprehensive health care services. --If costs exceed negotiated amount, contracting provider suffers loss; --State also at risk as federal matching funds set at 95% of AAPCC levels; --In 10 of state's 15 counties, program eligibles have two or more prepaid health plans to choose from.			Case management system used to authorize access to all services for enrollees.

ARIZONA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1983	No change						
1984 [Effec. 5/5/84]	Revised existing payment system.			State will calculate adjusted billed charge factor to assure that hospital payments are held constant at April 1, 1984 level. --This cap remains in effect until Oct. 1, 1985, or until next rate increase implemented, whichever first; --One-time exception allowed for any hospital which had filed for a rate increase before May 1, 1984.			
1985	No change						

ARKANSAS

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					Limit of 26 days per FY for elective admissions; non-elective days beyond 26 must be medically necessary.
1981							Limits LOS to 50th percentile based on PAS diagnosis, unless medically justified. Prior authorization required for certain surgical procedures.
1982							Raised day limit from 50th to 75th percentile of PAS.
1983							Changed LOS limits back to 50th percentile.
1984 [Effec. 2/13/84-6/30/84]				State reduced hospital payments to 80% of existing interim payment rates with no retrospective settlement. Designed as interim measure.			Dropped 50th percentile LOS limit during interim period. New limit is 9 days; EPSDT recipients can seek extension.

ARKANSAS (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1984 [Effec. 7/1/84]	Mandatory, prospective reimbursement system. Applies rate of increase controls. No peer group ceilings are used.	Medicaid 98 hospitals	Per diem	Prospective per diems based on FY 1982 costs with universal rate year each July 1 are calculated as follows: --Allowable operating costs in base year trended to end of rate year using DRI Natl. Market Basket; --Allowable capital cost component added, after minimum occupancy factor is applied.	Based on Medicare.	Minimum Occupancy Capital costs per diem are adjusted as follows: --Applies 60% occupancy factor to hospitals ≤100 beds. --Applies 75% factor to hospitals > 100 beds. Uncompensated Care Special consideration given to facilities serving disproportionate number Medicaid eligibles; defined as Medicaid days >20% of total. Case Mix No explicit adj. is made.	Imposed limit of 35 days per fiscal year for all recipients. Extensions for EPSDT eligibles possible in life-threatening situations. This is in addition to LOS limit of 50th percentile of PAS.
1985	No change						

CALIFORNIA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980 [Effec. 7/1/80]	Mandatory, retrospective reimbursement system. Applies rate of increase controls. No peer group ceilings are used.	Medicaid 512 hospitals	Case rate per discharge at final settlement	Retrospective case rate set with moving base year as the hospital accounting year prior to rate year; rate year is by hospital FY starting July 1. --Rate is lesser of customary charges, Medicare standards, or all-inclusive rate per discharge calculated as follows: --Base year costs are inflated using cost index with hospital-specific weights and general price indicators like CPI, WPI, plus 1% for intensity [If needed, weights taken from Natl. Hospital Input Price Index; --Adjustments made for actual changes in input price index; --Following costs are passed-through: depreciation, rent, interest, malpractice insur., utilities.	Based on Medicare	Volume Changes Rate adjusted for cost changes due to volume fluctuation. Hospital receives variable costs based on institution-specific data; if unavailable, a fixed/variable ratio of 50/50 used. Case Mix Administrative adj. possible based on changes in case mix.	Prior authorization required for all non-emergency admissions; and stays limited by diagnosis based on Medi-Cal's LOS schedule.
1981 [Effec. 7/1/81]	Revised existing retrospective system.					Occupancy Rates reduced proportionately if average occupancy rate < 55%. Reduction applied only to fixed costs; new, rural hospitals exempted.	

CALIFORNIA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1982 [Effec. 1/1/82]	Revised existing system.			--Established peer grouping system based on cluster analysis, producing 9 acute care groups; --Hospitals with average costs per discharge > peer group median are penalized for excess by not being reimbursed in full for pass-through costs.		Case Mix Rate per discharge adj. at settlement if hospital's case mix has materially changed from prior year. Percentage increase in relative case mix by Major Diagnostic Category is multiplied by Hospital Cost Index. Uncompensated Care Introduced concept of automatic adj. for facilities whose revenue from serving low-income patients exceeds 31% of total gross revenues. If these facilities have costs per discharge > peer group cutoff, they will be reimbursed at a percentage of difference between median and its cost, according to a sliding scale.	Prior authorization required for all elective surgical procedures. No coverage for procedures that could be on outpatient basis.

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1983 [Effec. 2/83]	Established Selective Provider Contracting Program which relies on prospectively negotiated contracts with providers. Contracting applies to approx. 1/2 of hospitals [all urban areas] and over 3/4 of hospitalizations.	Medicaid	Per diem	All-inclusive per diems negotiated individually with eligible hospitals on regional basis. Contracting phase-in began Feb., completed by July 1983. --State divided into 137 Health Facilities Planning Areas; in 56 of these, hospitals encouraged to bid competitively to provide portion of projected bed/days needed by Medi-Cal in coming year; --Contracted price is firm; hospital must absorb costs that exceed negotiated level; --Medi-Cal patients must go to a contract hospital; participating facilities must treat them; --Contracting requirements don´t apply to emergency services, HMOs and other organized health systems, or childrens´ hospitals; --Aggregate payments can´t exceed customary charges or Medicare levels.		Uncompensated Care Facilities with special needs taken into account in establishing rates under contracting process.	
	Hospitals in areas not covered by contracting [mostly rural] remain under existing retrospective system with peer group ceilings.	Medicaid	Case per discharge				

CALIFORNIA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
	Authorized private insurance companies and nonprofit health plans to contract with preferred providers in companion legislation to bill extablishing Medi-Cal contracting. Companies can negotiate reduced rates directly with hospitals, physicians.	Blue Cross Commercial Payers	Negotiated charges				
[Effec. 7/1/83]				--Peer group ceiling under old State Plan Method increased from median to 60th percentile.			
1984	Revised existing system.			--Changed reimbursement method for childrens´ hospitals from reasonable cost basis to case mix basis. New coding system creates 215 pediatric diagnostic categories analogous to Major Diagnostic Categories under Medicare DRG system. --State´s policy in second round of annual negotiations with contracting providers is to continue strategy of no net increases from first year, insofar as possible.			

COLORADO

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Mandatory, prospective reimbursement system. Applies rate of increase controls, together with peer group ceilings.	Medicaid 84 hospitals	Per diem	Prospective per diems set by base period rate [originally FY 1976] brought forward for intervening years; rate year is current hospital FY. Note: Periodically, state may substitute more recent base year. --Trend factor is change in CPI-W for urban consumers for 12-month period ending 90 days before start of state's new FY; --Add-ons may be included for case mix changes or price increases; --Resulting prospective rate can't exceed 75th percentile of HAS grouping data, a classification system based on hospital size, services, and location.	Based on Medicare; excludes routine nursing differential	Basically no retroactive adjustments made; case mix changes and price increases above CPI are considered during initial rate-setting process.	Limits LOS to 50th percentile based on PAS diagnosis, unless medically justified.
1981	No change						
1982	No change						
1983							Moratorium on non-emergency surgery from March 1 - June 30.

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1984 [Effec. 4/1/84]	Mandatory, prospective, reimbursement system. Applies rate of increase controls. Note: This system runs concurrently with pre-existing one. Hospitals given choice of payment method. Only 6 hospitals are on case payment system as yet.	Medicaid	Case per admission	Determines Average Gross Revenue Per Inpatient Stay as follows: --Total allowable charges in base period [July 1 - Dec. 31, 1983] updated by a target rate of increase in 6-month intervals; --Target rate is average rate of increase of CPI wage earnings factor plus Colorado Hospital Assoc. Market Basket Guidelines, based on natl. and regional forecasts and hospital monitored data; --If increase in revenue per case is > target rate, allowable charges are reduced by excess amount; --If revenue per case is increased by < target, hospital keeps half of amount under target rate level.	Excludes bad debts		
1985	No change						

CONNECTICUT

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles. NOTE: Medicaid payment levels also affected to extent overall net hospital revenue controls contain expenditures. [See below.]	35 hospitals Medicaid			Based on Medicare; excludes: routine nursing differential		
	Mandatory, prospective reimbursement system. Controls net revenues, defined as "actual receipts from third-party payers." Budget review and informal negotiation system screens base year costs; applies prospective rate of increase controls.	Commercials Self-pay	Charges	Commission approves both net revenue and capital expenditures budgets for each hospital as follows: --Base year is current year; rate year begins Oct 1 using uniform reporting system; --Hospitals classified into 4 peer groups on basis of total general fund expenses; --Applies "overall reasonableness test" or screen to hospital operating expenses; net revenues for rate year can't exceed current year's revenue [adjusted for volume] by more than inflation factor plus 2%; --Hospitals that fail screen are subject to more detailed review;	Financial requirements include: routine care ancillary services working capital bad debts charity care	Volume Changes Retrospectively adjusts for volume changes assuming expenses due to volume are 50% variable. Case Mix No explicit adj. is made.	CON Link Rate Commission also has CON authority. Budget requests often approved contingent on modification or withdrawal of future investment plans.

CONNECTICUT (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Base year costs divided into 3 cost centers: general, routine & ancillary services, and compared to peer group; --If cluster costs >110% of median, departmental cost centers within cluster also screened using 110% criterion --excess amounts challenged; --Base costs adjusted for inflation using external proxies, i.e., CPI, WPI, ECI, with no retroactive adjustment allowed; --Capital, malpractice insurance and physicians´ costs are evaluated separately; --Hospital´s net revenue budget translated into schedule of charges; --Excess revenues applied to next year´s financial requirements.			
		Blue Cross	Per diem	BC contracts with hospitals employ prospective payment: --Proposed budget compared to prior year´s on departmental basis, using 6 months´ actual cost data;			BC aggressively promotes pre-admission testing and utilization review.

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Mediation panel resolves disagreements; --Most hospitals elect to share risks equally with BC.			
1981	No change; Medicaid continues to use Medicare principles of reimbursement.						
1982							Medicaid limit of one day on certain pre-operative hospital stays. Requires second opinion for certain elective surgical procedures.
1983	No change						
1984	No change						
1985 [will become operational Oct]	Mandatory, prospective reimbursement system. Controls net revenues. Will operate as rate of increase control system; will employ peer group comparisons	Program design calls for all payers. [will apply for Medicaid/ Medicare waivers]	Case per admission	Prospective per case rates set as follows: --Base year is hospital fiscal year starting Oct 1983, rate year is fiscal year beginning Oct 1985; --Base allowable operating costs are 75% of hospital´s	Financial requirements include: routine care ancillary services education costs bad debts charity care capital costs	Volume Changes Allowable revenues can be adjusted in following rate year if actual admissions >101.5% <98.5% of budgeted admissions; Variable cost factor set at 50%.	

CONNECTICUT (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
	to determine allowable costs. Commission will compute gross inpatient service revenue cap; hospitals to establish fixed charges per case to yield approved revenues. Note: Medicaid will continue to follow Medicare retrospective cost principles unless and until a waiver is obtained from HCFA.			cost per admission plus 25% of peer group's cost per admission; [NOTE: For rate year 1986 the blend will be 50% of hospitals per admission costs plus 50% of peer group's.] --Base inflated to rate year using DRI National Market Basket, adjustments allowed for misprojections of non-salary items; --Total operating costs plus allowed capital, education, & uncompensated care costs yields allowable revenue.		Case Mix In developing a formula to compute cost per admission, commission will take into account different costs associated with different illnesses. Uncompensated Care Allowable level of uncompensated care is under development.	

DELAWARE

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retro-spective cost reimbursement principles.	Medicaid 8 hospitals					
1981	No change						
1982	No change						
1983	No change						
1984	No change						
1985	No change						

DISTRICT OF COLUMBIA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					
1981	No change						
1982							Prior authorization required for certain specific procedures.
1983 [Effec. 1/1/83]	Mandatory, prospective reimbursement system. Budget negotiation system applies rate of increase controls, subject to areawide Maxicap or overall ceiling on hospital expenditures. No peer group ceilings are used.	Medicaid 13 hospitals	Case per discharge	Annual contracts negotiated with each hospital using fixed base year ending between 9/82 and 6/83; rate year is hospital FY 1983. --Allowable operating costs trended forward annually using DRI Natl. Market Basket; --Capital costs are passed through. --No retroactive adj. made if actual inflation differs from projected amount. --Sum of individual hospital budgets may not exceed Maxicap.	Based on Medicare	Volume Changes Adj. made if actual number of discharges differs from projected levels. Case Mix No explicit adj. is made.	PSRO review of medical necessity.
1984	No change						
1985	Revised existing payment system.			--There is no longer an areawide Maxicap, and each individual hospital's budget must not exceed its own specific cap.			

FLORIDA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles	Medicaid					Limit of 45 days per patient per fiscal year.
	Retrospective review of hospital budgets. Mandatory disclosure but voluntary compliance by all hospitals.	Blue Cross Commercial Payers Self-Pay		State Board may initiate reviews of hospital budgets and proposed rates. Allows public disclosure of hospitals with highest charges; i.e., above 80th percentile.			
1981 [Effec. 7/1/81]	Mandatory, prospective reimbursement system. Applies rate of increase controls, together with peer group ceilings.	Medicaid 215 hospitals	Per diem	Prospective per diems based on latest cost report are calculated as follows: --First reduces a hospital's routine operating costs if above Medicare Sec. 223 limits; --Base year operating costs adjusted for inflation using DRI National Market Basket adjusted for regional input prices and Florida Price Level Index; --Reimbursement ceiling periods are effective 1/1 thru 6/30 and 7/1 thru 12/31 of each year; --Prospective ceilings are set for each Florida county equal to sum of average per diem plus standard deviation of variable cost per diem, times Florida Price Level Index for county;	Based on Medicare, includes: routine operating ancillary services Excludes: bad debts routine nursing differential	Uncompensated Care Temporary exemption from county ceiling may be granted to hospital which treats largest share of indigent patients in county. Case Mix No explicit adj. is made.	Certain surgical procedures require prior authorization. Excludes elective surgical procedures.

FLORIDA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Actual costs are not reconciled once per diem is trended forward and rate ceiling set.			
1982	No change						
1983	No change						
1984	No change						
1985 [Effec. 2/1/85]	Mandatory, prospective reimbursement system. Requires annual review of hospital budgets. Applies rate of increase controls for gross hospital operating revenue, together with peer group ceilings.	Blue Cross Commercial payers Self-pay	Case Per Admission	Prospective budgets approved as follows: --Base year is hospital FY 1984; rate year is FY on or after 2/1/85; --Hospitals categorized into 10 acute care and 7 specialty care peer groups by status, service and case mix, census, geography; --Hospital with gross revenue per admission ≥80th percentile for its group is subject to budget review and may face disallowances; --Hospital below 80th percentile trigger can increase average revenues per admission by DRI National Market Basket inflation factor plus 5% in CY 1985, 4% in CY 1986, and 3% thereafter.		Indigent Care Pool Placed an assessment on hospital operating revenue of 1% first year and 1.5% each year thereafter, to help fund expansion in Medicaid eligibility. Case Mix Changes in a hospital's case mix can be taken into account during the appeals process.	In extreme cases, Hospital Cost Containment Board may void a hospital's CON eligibility.

GEORGIA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles	Medicaid					Prior authorization required for certain specific procedures.
1981 [Effec. 1/1/81]	Mandatory, retrospective reimbursement system. Applies rate of increase controls together with peer group ceilings. Providers phased in by fiscal year; hospitals not subject to alternative system follow Medicare rules.	Medicaid 205 hospitals	Case per admission	Target rates set by calculating a crude mean per case cost. --FY1978 or FY1979 per case cost then inflated through fiscal year beginning 1/1/81 based on regional hospital rates developed by AHA, wage movements from BLS, and GNP deflator; --Besides trend factor + 1% for intensity, hospitals below group limit in base year are eligible for efficiency incentive of up to 2% of individual revenues; --Peer group limits set at 130% of mean per case cost; --There are 14 peer groups based on medical similarity of patients using DRG-categorization approach.	Based on Medicare, includes: routine operating ancillary services capital education; Excludes: routine nursing differential	Due to changes in case mix intensity and volume. Due to actual price changes in non-labor inflation indicators.	Limit of 20 days per calendar year. No weekend admissions, except emergencies. Limits preoperative days for elective surgery to 1, unless medically justified.
1982							Increases day limit to 25.

GEORGIA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1983 [Effec. 1/1/83]	Mandatory, prospective reimbursement system. Applies rate of increase controls. No peer group ceilings are used.	Medicaid	Case per admission	Prospective per case rates set with FY1982 as moving base year; rate year begins with admissions on or after 1/1/83. --Hospital-specific rates for each case trended forward biannually; --Operating costs, depreciation, and MD costs inflated using DRI National Hospital Market Basket adjusted for regional costs, plus 1% intensity allowance; --Add capital cost component.	Based on Medicare	Case Mix No explicit adj. is made. Volume Changes Reimbursement limits set for each hospital at 100% of admissions in prior fiscal year [7/1-6/30]. Admissions >100% but ≤103% reimbursed at 50% of rate per case; admissions >103% at 25% of rate.	Drops 25-day limit.
1984	No change						
1985 [Effec. 1/1/85]				Established an outlier claims adjustment, based on cost to charge rates for highest cost admission category.		Uncompensated Care Hospitals with Medicaid costs >15% of total revenue or most Medicaid admissions in SMSA, eligible for 2% intensity allowance. Volume Changes Hospitals paid in full for increases up to 3% above number of admissions during prior fiscal year.	

HAWAII

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					Prior authorization required for all non-emergency admissions. Limit of 8 days on med./surg. admissions, 4 days on maternity, and 2 days on tonsilectomy/adenoidectomy; unless extension medically justified.
1981	No change						
1982	No change						
1983	No change						
1984	No change						
1985	Hawaii hopes to win HCFA approval for mandatory prospective reimbursement system which would apply rate of increase controls to 2-year lagged base period, together with peer group ceilings.	Medicaid 21 hospitals	Per diem for routine costs. Case per discharge for ancillary costs.				

IDAHO

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Mandatory, retrospective reimbursement system. Applies rate of increase controls. No peer group ceilings are used.	Medicaid 47 hospitals	Case Per Admission	Hospitals reimbursed lesser of customary charges or maximum allowable case rate as determined below: --Base year is hospital reporting period prior to current year; rate year is hospital FY beginning on or after 10/1/79; --Base year operating costs updated by a state-derived Hospital Cost Index using hospital-specific weights, and economic indices from DRI, CPI, WPI; --Index adjusted to reflect actual inflation; --Operating cost limit increased by untrended capital-related costs; --Upper limits can't exceed Medicare cost limits; --Allows end-of-year final settlement.	Based on Medicare	Volume Changes Operating costs adjusted by following formulae: Hospitals < 4,000 Medicaid Admissions If admissions = 90-102% of base, there is no change; If admissions = 85-90% or 102-115% of base, decreases or increases set at 50% of average cost per admission. Hospitals ≥ 4,000 Medicaid Admissions Same as above, except 94% is substituted for 90%. Greater differences may be determined individually based on actual costs. Case Mix No explicit adj. is made.	Limit of 40 days per admission.
1981	No change						
1982							Changed limit from 40 days per admission to 40 days per year.

IDAHO (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1983	No change						
1984							Prior authorization required for certain surgical procedures.
1985	No change						

ILLINOIS

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					Limit of 45 days per year.
1981				--Limited hospital rate increases to 2% within retrospective system.			No coverage for certain surgical procedures that could be on outpatient basis.
[Effec. 10/1/81]	Note: Phase-in to new system begun. See below.						
1982 [Phase-in completed 7/1/82]	Mandatory prospective reimbursement system. Applies rate of increase controls, subject to overall state appropriation for hospital expenditures. Hospitals grouped according to 218 primary diagnosis categories and status in order to set utilization maximums only, not direct rates. No peer group ceilings are applied.	Medicaid 245 hospitals	Per diem	Prospective per diems based on latest available cost report as of 12/81, beginning with services on or after 10/1/81 are calculated as follows: --Base year costs updated from midpoint of year to Jan. 1, 1983 using DRI Natl. Market Basket; --If total projected payments to all hospitals exceed budgetary appropriations, rates adjusted downward proportionately so as not to exceed limit.	Based on Medicare	Volume Changes FY 1983 utilization maximums set by increasing FY 1982 utilization by 2.6% to allow for caseload increases plus applying reduction factor based on excess days over hospital group's 80th percentile LOS. If a hospital's actual utilization exceeds estimated amount, day limits may be revised provided total payment for hospital services during FY 1983 does not change. Uncompensated Care Special relief for hospitals serving high volume of low income patients, i.e., Medicaid days at least 35%	Limits LOS by PAS diagnosis.

ILLINOIS (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
						of total or combined Medicaid/ Medicare/G.A. days at least 65% of total. Rates increased by 1% for each 1% over 35% Medicaid day total. Case Mix No explicit adj. is made.	
1983				For services rendered between March 3 and June 30, 1983, hospital rates set under existing plan were reduced by 7.5%.			Imposed copayment of $2-$3 per inpatient hospital day.
[Effec. 7/1/83]	Made major revisions to existing prospective payment methodology. New final rates subject to peer group ceilings too.	Medicaid	Per diem	Lag between base year and rate year increased from approx. 1-1/2 to 2-1/2 years; i.e., CY 1981 used to define base year costs for FY 1984 rates. --Instituted 6 acute care peer groups based on following variables: percentage inpatient days in short-term care units, number of residency programs, scope of service, and bed size; --Final rate for hospital with DRI-updated costs > group mean will be limited		Volume Changes FY 1984 utilization maximums set by increasing each hospital's 1983 base by 4% for projected caseload increases. Reduction factor still applied to adjusted base. Adjustment allowed for actual utilization in base period.	

ILLINOIS (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1984 [Effec. 7/1/84]	Continued revisions to prospective per diem system. Began testing a case-mix payment system called Primary Diagnosis Group in 7 hospitals; similar to Medicare DRG system, but with only 218 categories.		Per diem Case per discharge	--Individual hospital's rate is now lesser of its FY trended cost or its peer group's projected 65th percentile cost.		Volume Changes Continues to use same reduction factor and case-load adjustment to set utilization maximums as in FY 1983. In addition, set aggregate statewide limit for hospital days. Hospitals able to justify exceeding their individual limits will be paid, provided statewide cap not exceeded. If state maximum exceeded, hospitals above their limits will be paid 65% of their FY 1985 per diem rates. Uncompensated Care Created state fund to provide relief to hospitals with Medicaid days > 3% of total inpatient days. Case Mix Portion of fund for hospitals whose 1981 Medicare Case Mix Index > mean case mix index of Illinois in its PDG peer group by 15% or more.	

ILLINOIS (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1985 [Effec. 6/1/85]	Replaced existing prospective system with a Selective Provider Contracting Program. Budget constraints will be overall state hospital appropriations. Note: Experimental case-mix program will probably not be continued. Note: Rural and other hospitals who don't choose to enter contract system will likely remain under existing per diem system.	Medicaid	Per diem	As of June 1, 53 hospitals in Chicago area began under contracting system; phase-in to be completed by June 1, 1986. --Geographic regions established in state; Medicaid bed need projected by area; --All hospitals in region receive offer to bid on beds; --Once contracts awarded for 100% of estimated bed need, hospitals without contracts will be limited to Medicaid payment for emergency services only.			Prior authorization required for all admissions except emergencies and maternity.

INDIANA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid 114 hospitals					
1981	No change						
1982							Prior authorization required for certain specific procedures.
1983	No change						
1984	No change						
1985	Although still committed to Medicare retrospective cost principles for present, state has new legislative authority to establish a prospective payment system in future.						

IOWA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					
1981							Prior authorization required for certain elective surgical procedures.
1982 [Effec. 10/1/82]	Mandatory, prospective reimbursement system. Applies rate of increase controls. No peer group ceilings are used.	Medicaid 128 hospitals	Per diem	Prospective per diem based on hospital's prior FY 1981 costs trended forward for all rate periods beginning Oct 1, 1982 as follows: --Annual increase factor derived from Iowa Hospital Market Basket Index, using guidelines from National Hospital Input Price Index and DRI forecasts; --Should actual costs differ, adjustment made to subsequent year; --Final aggregate payment can't exceed hospital's aggregate customary charges or statewide average Medicare per diem cost; --Under payments or overpayments are adjusted at end of rate year, with no carryover into future periods as in some states.	Based on Medicare; excludes: routine nursing differentials.	Uncompensated Care Special need is defined as total Medicaid costs ≥51% of hospital's total allowable FY costs. No facilities anticipated to qualify. Case Mix No explicit adj. is made.	Limits LOS to 50th percentile by PAS diagnosis, unless longer stays medically justified. No reimbursement for certain surgical procedures that could be on outpatient basis. No payment for batteries of lab tests.

IOWA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1983	No change						
1984	No change						
1985							Prior authorization required for all admissions except maternity and emergency.

KANSAS

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					No coverage for certain surgical procedures that could be on outpatient basis, unless medically justified. No weekend admissions except emergencies.
1981	No change						
1982							Limits LOS to 50th percentile based on PAS diagnosis, unless medically justified. No coverage for admissions batteries of lab tests.
1983 [Effec. 7/1/83]	Mandatory, prospective reimbursement system. Applies negotiated rate of increase controls, together with peer group ceilings.	Medicaid 146 hospitals	Per diem	Prospective per diems based on hospitals´ FY 1981 are set each July 1st as follows: --Allowable base year costs updated to state´s FY 1984 rate year at state determined percentage; 3-year lag exists in data; --All future inflation factors to be negotiated annually with hospital association; --Adjusted per diems ranked from highest to lowest [excluding teaching costs];	Based on Medicare	Volume Changes Adj. applies only as threshold to limit size of per diem for number of Medicaid days above negotiated industry maximum. Inflation and Case Mix factors considered as grounds for appeal if hospital´s actual per diem varies 10% or more from prospective rate.	Prior authorization required for certain elective surgical procedures. Limits coverage of mother´s stay for normal deliveries to 2 days.

KANSAS (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Hospitals with costs ≤ mean considered lower cost and receive per diem as calculated with no day limits; --Higher cost hospitals, i.e., above mean, receive individual per diems up to a "program day maximum," defined as a negotiated percentage of base year utilization [state FY 1984 limit is 78% of 1981 Medicaid days]; --Days in excess of program maximum receive a second, lower rate equal to mean of all lower cost hospitals plus any teaching costs.		Uncompensated Care If number of Medicaid eligibles in hospital's catchment area has increased, then ratio of current average to 1981 average is multiplied by current day limitation to calculate revised day limitation.	
1984							No coverage for elective surgery; EPSDT particpants exempted.
1985	No change						

KENTUCKY

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles	Medicaid					Limit of 21 days per admission; approval required for stays beyond 7 days.
1981 [Effec. 3/1/81]	Mandatory, prospective reimbursement system. Applies rate of increase controls, together with peer group ceilings.	Medicaid 106 hospitals	Per diem	Prospective per diems based on latest cost report are calculated as follows: --Base year is calendar year prior to universal rate year; --Base year operating and professional costs are trended to Jan. 1 rate year and adjusted for inflation using DRI Market Basket [adjustment allowed if actual inflation differs]; --Upper limit set on inpatient operating costs at mean plus 1 SD for each of 5 bed-size categories; --A capital cost per diem is also determined.	Based on Medicare, includes: routine operating ancillary services capital education Excludes: routine nursing differential	Occupancy Medicaid inpatient capital costs are adjusted according to a 60% minimum occupancy requirement for hospitals with 100 beds or less, and 70% for hospitals with >100 beds. Case Mix No explicit adj. is made.	Reduced limit to 14 days per admission, with no recurrent admission within 30 days. No weekend admissions, except emergencies. Required preadmission lab tests. Eliminated payment for standard battery of lab tests.
1982 [Effec. 7/1/82]				Amended way of calculating upper limit, redefining it as 110% of weighted median inpatient operating cost per diem for each hospital group.			

KENTUCKY (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1983 [Effec. 7/1/83]				Lowered upper limit to 105% of weighted median inpatient cost per diem for each hospital group.	Disallowed education costs.	Uncompensated Care For hospitals with significant Medicaid caseload [20% or more], upper limit is 120% of peer group median.	Prior authorization required for all hospital admissions except maternity and emergency services.
1984	No change						
1985 [Effec. 1/1/85]						For universal rate years beginning on or after 1/1/85, no adjustment will be made if actual inflation differs from projected index.	

LOUISIANA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles	Medicaid					Increased limit from 10 to 15 days per calendar year; longer stays can be pre-authorized. Prior authorization required for certain specific procedures.
1981	No change						
1982 [Effec. 10/1/82]	Mandatory, retrospective reimbursement system. Similar to Medicare TEFRA limits; applies target rate limits and rate of increase controls. No peer group ceilings are used.	Medicaid 138 hospitals	Case per discharge	Establishes per discharge rate each July 1, with FY 1982 as fixed base year. --Individual target rates set based on ratio of operating costs to discharges, trended forward by DRI Natl. Market Basket, plus 1% for intensity; --Capital, education and insurance costs passed through; --Totally exempts neonatal and pediatric intensive care services and burn unit costs from target rate provisions; --Provider incentives If hospital costs exceed target, it receives only 25% of excess; If costs < target, it receives 50% of difference, up to 5% of target rate;	Based on Medicare, excludes routine nursing differential	Case Mix Exceptions possible for service changes which result in significant change to cost per discharge.	

LOUISIANA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Provides for end-of-year cost settlement.			
1983	No change						
1984 [Effec. 10/1/84]				Revised target rate percentage increase to market basket index plus 1/4 of one percentage point for intensity.			
1985	No change						

MAINE

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles used for public beneficiaries.	Medicaid					Prior authorization required for stays beyond 60 days, excluding stays for intensive/coronary care.
	Mandatory, prospective reimbursement system with voluntary compliance.	Charge-based	Charges	Voluntary review org. classifies hospitals into peer groups, employs revenue and expense screens based on inter-hospital comparisons. Issues opinion on reasonableness of proposed budget.			
1981	No change						
1982							Prior authorization required for certain select services.
1983							Prior authorization requirement tightened to apply to stays beyond 30 days.
1984 [Effec. 10/1/84]	Mandatory, prospective reimbursement system. Controls total revenues. Applies rate of increase controls, subject to a gross revenue limit. No peer group ceilings are used.	Program design calls for all payers. [will apply for Medicaid/ Medicare waivers] 44 hospitals	Global charges	Each hospital's gross patient service revenue limit calculated as follows: --Base year is hospital's most recent fiscal year ending before 6/30/84, rate years phased-in beginning 10/1/84;	Financial requirements include: routine care ancillary services working capital debt service charity care bad debts	Commission sets revenue limits which take into account case mix and volume changes. Adjustment methodology is being refined as system phased-in.	

MAINE (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
	Each payer contributes its share of apportioned charges.			--Inflate allowable base year costs using DRI National Market Basket with regional adjustments; --Ceiling on revenues is set at 3% above adjusted base year costs for large hospitals [>55 beds], and 5% for small hospitals [55 or fewer beds]; --A penalty is applied equal to 120% of amount above 3% margin; --Allows incentive of 50% of difference between actual costs and rate year financial requirements. Note: Medicaid's discount reduced from 25% to 18%. BC discount reduced from 16% to 9%.			
1985	Medicaid will continue to follow Medicare retrospective cost principles until a waiver is obtained from HCFA.						

MARYLAND

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Mandatory, prospective reimbursement system. Controls total revenues. Health Services Cost Review Commission operates three systems concurrently: (1) Full or partial budget review [done in seventies, seldom repeated] (2) Formula-based Inflation Adjustment [most widely chosen] (3) Guaranteed Inpatient Revenue (GIR) [19 hospitals selected, including largest]	All payers 54 hospitals	(1) Under budget or rate review average charge is set per patient service center [e.g. rate per ICU patient day; or rate per CAT scan]. (2) Inflation Adjustment System [IAS] computes annual percentage increase to existing hospital-specific rates. (3) GIR system pays case per discharge.	Budget Review System Sets average rates for each department or patient service center by dividing total approved costs for each dept. by projected units of service [e.g., operating room charges based on minutes of OR use]. --Base year is current fiscal year; rate year is following fiscal year. Base year inflated by use of BLS indices for labor and non-labor costs. --Hospitals must absorb difference between established rates and actual costs. Minimal use of inter-hospital comparisons for rate setting purposes, as opposed to analytic tools.	Routine services Ancillary services Capital costs Working capital Bad debts Charity care	Budget Review System Total approved revenues derived from direct and allocated indirect dept. costs plus following: (A) Capital Facilities Allowance used in lieu of depreciation. For buildings, hospitals choose either funds to finance 20% down payment on new facility, or cash to finance principal and interest on current facility, whichever is greater. For equipment, replacement cost is allowed. (B) Uncompensated Care--usually 3-5% allowed for bad debts and charity care, based on historical experience. (C) Working Capital Allowance--Commission allows an additional 2%. (D) Payor Differential--Rates adjusted to allow discounts for major third-party payers, i.e., 6% to Medicaid, Medicare and Blue Cross.	Links to CON Program Commission can challenge a CON decision by: --withholding a "comfort order" or license; --refusing to pass through all costs associated with approved capital expenditures. Prior authorization required for certain specific procedures. Prior authorization required for certain surgical procedures.

MARYLAND (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				Inflation Adjustment System IAS formula uses 12 months actual data to adjust initial rates for inflation. --Factor cost inflation adjustments are made for: --salaries & fringes --food supplies, utilities, other --capital equipment allowance. --Proxies taken from BLS wholesale and consumer price indices; weights are hospital-specific. --Maryland hospitals divided into 3 geographic areas: Baltimore metro. area; suburbs use Washington DC index; and remaining hospitals use U.S. average. --Provider penalties: If average rates charged during year exceed allowed corridors, 140% of amount overcharged plus interest will be taken out of next year's rates.		Inflation Adjustment System: Volume Adjustment pays only variable cost for volume increases. Projected volume is multiplied by allowed rate and variable cost factor [60% for routine patient care centers; 40% for ancillary]. For decreases in projected volume, hospital keeps fixed costs.	

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				Price variances > approved rate but < corridor are recovered at actual amount plus interest.			
				Guaranteed Inpatient Revenue System Base year data on live discharges are classified by payer and diagnosis, using some form of DRGs or ICD-9 Principal Diagnosis Codes. Different diagnostic classification systems are applied to different hospitals. --"Resource standards" for each hospital established by computing its average charge for each diagnostic category in its base year, generally two years prior, then inflating it by rates developed in IAS system [plus 1% for growth and technology]. --Hospitals guaranteed this amount for every such case treated during rate period.		Guaranteed Inpatient Revenue System Provider Rewards If actual revenue is <GIR, hospital given variable cost of that amount in next year's rates. If actual revenue is >GIR, hospital must pay back 100% of difference. Volume Adjustment Pays only variable cost for each admission over projected amount. If admissions decrease, hospital can recover portion associated with fixed costs. Adjustments made to following year's rates.	

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Note: Under GIR, individual patients still charged for services they use; case mix adj. is calculated at time of hospital's inflation adj., and included in rates prospectively. Unlike Medicare PPS and New Jersey DRG system, where individual patients charged a prospective limit per case which is average per case amount.			
1981							Limit of 20 days per spell of illness, except for some tertiary services. Requires pre-admission review for elective admissions. Limits pre-operative days to 1, unless medically justified. No longer covers administratively necessary days.
1982 [Effec. 4/82]	Revised screening policy used in Inflation Adjustment System.			To participate in IAS, hospitals must pass a case mix adjusted cost per case screen.			

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Screen is set at twice average factor cost allowed all hospitals, and is used as limit because no inflation adj. is allowed that would bring hospital above screen.			
1983	Revised method of inter-hospital comparisons used in full rate review. Introduced fixed peer groupings.			Formal Interhospital Cost Comparison Methodology established 7 peer groups based on following variables: location, extreme size variations, extreme payer mix differences, and for first time, case mix intensity and scope of services.		Bad Debt/Charity Care Developed reasonableness test for uncompensated care to replace calculations based on historical percentages. Uses regression analysis to project reasonable amounts; hospitals may appeal.	
	Revised GIR payment system. 37 of 54 hospitals representing 86% of revenue were on either original GIR plan, or amended version. Remaining 17 hospitals were on IAS system.			Traditionally GIR system altered in two ways: --Modified GIR option made available to smaller, rural hospitals. Reduces number of diagnoses included and places hospitals in larger peer groups; --New Capitation Payment System guarantees hospitals specified total revenue amount independent of amounts of services provided			

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				or costs incurred. Base year revenues are adjusted for inflation; plus 1% for intensity and additional 1% allowance for population growth.			
1984						Volume Adjustment Revised ratio of fixed/variable costs to be a 50/50 split, regardless of revenue center. This ratio applies to both IAS and GIR systems.	Modified limit from 20 days per spell of illness to 20 days per admission. Established new limit on days based on DRGs. Payment limited to 120% of average Mayland Medicaid LOS for that DRG. [This regulation eliminates previous 20 day limit effective 10/15/84.]
1985	Currently, 48 hospitals are on some form of GIR system, and 6 hospitals are on IAS plan. Note: If a hospital is not satisfied with its rates, or if Commission requires a closer look at a high-cost hospital, a detailed budget review may be performed. This alternative is						

MASSACHUSETTS

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Mandatory, prospective reimbursement system. Commission uses different payment methodologies for different payers:	121 hospitals					
	(1) Applies rate of increase controls to base year.	Medicaid: Controls 15% of statewide hospital expenditures	Per diem	Under Medicaid Prospective per diem set using latest cost report. A two-year base lag is inflated to each hospital's fiscal year as follows: --Operating costs inflated from base year to intermediate year using both actual data and projections; --Next, costs projected from intermediate to rate year and through rate year using index derived from CPI, WPI, Commerce Dept. and other sources, adjusted with statewide weights; --Base-year uninflated depreciation and interest is added; --Routine per diem costs can't exceed Medicare limits.	Based on Medicare; excludes bad debt and free care.	Under Medicaid Hospitals allowed higher of actual days or following minimum occupancy levels: Dept./Teach./Non-Teach Maternity / 65% / 65% Pediatric / 80% / 75% Med/Surg. / 85% / 80% Case Mix No explicit adj. is made	Second opinion required for certain elective surgical procedures.
	(2) Budget review system approves net patient services revenue and charges as they generate appropriate revenue.	Commercial and self-payer: Controls 15% of statewide hospital expenditures.	Charges				
	(3) Reviews proposed contracts between Blue Cross and hospitals and rates developed under contracts.	Blue Cross: Controls 35% of statewide hospital expenditures.	Routine per diem; ancillary service charges.				
	No system applies peer group ceilings.						

MASSACHUSETTS (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				Under charge-based Chapter 409 requires hospitals to annually submit past, current and prospective year budgets. Commission approves reasonable financial requirements comprised of operating, capital and working capital costs. --Applies weighted average inflation factor to base year with 2-year lag and external forecast indicators similar to Medicaid; --But inflation index is unique to each hospital, weighted according to individual hospital's cost structure; --Inflation not allowed on depreciation, interest, bad debt and free care; --No adjustment for actual costs; --In July 1980 an 11.5% cap placed on charge increases statewide for FY 1981.	Based on Medicare; exceptions: asset useful life determined by AHA guidelines; bad debt and free care not treated as a cost, but as deduction from revenues, not to exceed average historical % of gross patient revenues in base year.	Under charge-based Hospitals receive volume adjustments calculated using a 60:40 fixed/variable split.	

MASSACHUSETTS (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				Under Blue Cross Commission reviews/audits facilities' cost reports. Compares rate year costs to prior year to analyze incremental increases and volume changes. --Any amount in excess of audited costs may be denied. --Developing system to tighten limits on allowable annual increases and to perform cost comparison to determine reasonable Blue Cross rates.	BC definition of financial requirements.		Blue Cross has agreed to withdraw its contracts from hospitals recommended for closure by a Health Systems Agency (HSA).
1981 [Effec. 10/1/81]	Phase-in began for Medicaid's entry into all-payer system as discussed below.	Medicaid	Per diem	From 10/1/81 to 9/30/82 payments on interim per diem basis with end-of-year settlements.			
1982 [Effec. 10/1/82]	Introduced new mandatory, prospective reimbursement system. Controls total revenue. Sets prospective annual cap on each hospital's net patient care revenues.	107 hospitals All payers Medicaid	Pays percentage of charges.	Under Medicaid Under Chapter 372, Medicaid participates in "maximum allowable cost" or MAC program. MAC is sum of base	Based on Medicare; excludes bad debt	Casemix adustment possible based on changes to 1981 base. Poor data has precluded such adjustment to date.	

MASSACHUSETTS (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
	Applies rate of increase controls. Each payer responsible for its prorated share of charges. No peer group ceilings applied.			year actual costs adjusted for inflation as follows: --Initial base year is FY 1981 [FY 1982 for municipal hospitals], base for each future year is preceding year's MAC; --Inflation projected using same composite index used in old Chapter 409 charge control system applied to each hospital individually; --Index can be adjusted based on actual cost data; --Historical depreciation, interest and malpractice insurance are paid on actual cost basis outside of MAC computation; --A "productivity factor" guarantees that each hospital's Medicaid costs defined above will be reduced by 2% in FY 1983, plus an additional 4% in FY 1984 and FY 1985;		Volume Changes Volume adjustments calculated by functional service area using following corridors: Serv. / Upside / Downside ICU: 0% / 7% Gen.Serv. Unit: 0% / 7% Newborn: 0% / 7% Ancill.: >4% / >7% Breaking a corridor in first 3 categories yields a variable cost allowance of 50%. Transgressing of ancillary limits downward yields 60% allowance; upward produces 45%. Disproportionate Share Pays its share of charity care if 68% or more of a facility's revenues go to public beneficiaries of all programs, federal and local.	

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--A cost differential is applied, giving Medicaid a discount. In 1982, Medicaid paid only 72% statewide for services; --Final Medicaid reimbursement is determined by multiplying Medicaid costs [MAC-adjusted + other] times productivity factor times cost differential times Medicaid´s portion of charges.			
		Commerical self-pay	Percentage of charges	Under charge-based A hospital´s gross charges or Gross Patient Service Revenue [GPSR] is calculated by: --Multiplying base year-approved GPSR by approved inflation factor; --Adding actual costs for historical depreciation, interest, malpractice, plus share of bad debt and free care plus working capital allowance;	Also includes: bad debt free care working capital	Volume allowance calculated as for Medicaid.	

MASSACHUSETTS (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Final GPSR adjusted so as not to exceed existing charge differential between Blue Cross and charge-based patients [110% in 1982]; --Payment at approved charge levels is final.			
		Blue Cross	Percentage of charges	Under Blue Cross Blue Cross' Basis of Payment composed of hospital's total allowable base year costs trended forward as described above, plus following actual costs outside MAC: --Historical and price-level depreciation, interest, bad debts, free care, and malpractice; --Basis of Payment is multiplied by Blue Cross % of total hospital charges for each of 4 service categories: ICUs, General Service, Newborn, Ancillaries.		Volume allowance calculated as above.	

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
		Medicare [Waiver in effect until 10/1/85]	Charges	Under Medicare Follows same payment methodology as BC except: --Puts statewide cap on rise in Medicare costs equal to national average; --Applies 2% productivity factor; --Receives cost differential pegged at 85% of BC charge rate.	Depreciation and malpractice costs determined by Medicare rules not Blue Cross principles. Recognizes only bad debts associated with beneficiary cost-sharing, not its proportionate share of total bad debts.	Charity Care Reimburses its share of hospitals' charity care but only up to statewide limit of 1.4% of Blue Cross Basis of Payment.	
1983 [Effec. 10/1/83]				Switched to DRI National Market Basket but uses hospital-specific weights.			
1984 [Effec. 10/1/84]		Blue Cross		Following change in Blue Cross contract with hospitals: --Basis of Payment subject to 2% productivity reduction.		Charity Care Blue Cross and commercial insurers guarantee full coverage of hospitals' charity care for most facilities; subject to overall limit that private sector revenues not exceed 125% of hospital's total patient care costs.	

MASSACHUSETTS (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
		All payers				Volume Adopted new combined adjustment for case mix/volume changes to replace existing arrangements. Pays variable costs of 50% for increases; pays 50% for decreases exceeding corridor [set at 4% for FY 1985]. Uncompensated Care Hospitals required to provide same access to general relief patients as Medicaid recipients; services eligible for charity care payment by private payers as above.	
		Commercial Self-Pay		--GPSR is now subject to 2% productivity reduction.			
1985	No change						

MICHIGAN

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Mandatory, prospective reimbursement system. Combination budget review system with rate of increase controls. No peer group ceilings applied. Hospitals phased onto system over 5-year period.	Medicaid 206 hospitals	Per diem	Prospective per diems calculated using prior year cost report, with rate year beginning by hospital FY 1980. --Hospitals receive lesser of customary charges, Medicare cost standards, or reasonable cost as defined below; --Reasonable cost is sum of base year costs trended forward plus pass-throughs [plus any incentive in future years]; --During initial rate year, hospital's costs are adjusted downward to extent allowable base year costs exceed amount established by Hospital Cost Index for base year; --This index takes its weights and proxies from DRI Natl. Market Basket; price indicators are national including CPI, WPI; potentially an intensity factor can be added; --Hospitals classified into 2 groups based on Medicaid volume, and will be phased-in over 5 years;	Based on Medicare, excludes routine nursing differential	Volume Changes Automatic adj. made for volume increases which exceed corridors. Case Mix No explicit adj. is made.	Mandatory second opinion program for certain elective surgical procedures. No coverage for routine admissions batteries of tests.

MICHIGAN (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Hospitals phased-in first year are called "Group A," and represent top 20% ranked by their number Medicaid patient days, all other hospitals called "Group B"; --Group A hospitals may elect or be mandated to a budget review to determine appropriate rate of change in costs; --Each Group A hospital which doesn't request budget review may request incentive payments: If its rate of change in trended costs is < inflation index, it may receive 50% of net savings. --Group B hospitals to be phased-in.			
1981 [Effec. 10/1/81]	Revised existing system.			New base year defined as fixed 36-month average for period preceding first cost reporting period ending on or after Sept. 30, 1981. --Hospitals to be rebased once every 3 years. No retroactive adj. for inflation during current rate year.		Case Mix Adj. possible for changes in case mix which increase costs.	

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1982 [Effec. 10/1/82]	Revised existing system to include peer group ceilings.			Instituted a per diem operating cost limitation as follows: --Hospitals grouped by bed size into 4 urban and 3 rural classes; --Capital, education and insurance costs passed-through; --Operating costs adjusted & standardized for area wage levels, inflation, case mix and high Medicaid volume; --Each group's per diem limitation is defined as 75th percentile of per diem cost.		Volume Changes Amended adj. to apply to volume increases or decreases that exceed 1.5%. Uncompensated Care Hospitals with Medicaid/Crippled Children percentage of total days > 25% have their volume adjusted based on 1% or fraction for each 1% or fraction that total exceeds 25%. Case Mix Hospitals with changes in services that increase case mix index > 5%, are given relief from Operating Cost Limitation by % amount original case mix index would increase were it recalculated.	Limits LOS to 75th percentile by PAS diagnosis, unless medically justified. In addition, coverage limited to 18 days per year. Prior authorization required for certain specific procedures. No weekend admissions except emergencies. No coverage for procedures that could be on outpatient basis.
1983	No change						

MICHIGAN (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1984 [Effec. 10/1/84]	Revised existing system.			Hospitals to be rebased once every 4 years instead of every 3.			Prior authorization required for all elective admissions. Expanded mandatory second opinion surgical program.
1985 [Effec. 2/1/85]	Established new prospective system based on case mix using DRGs. Controls total revenues. Only initial DRG rates will be completely hospital-specific.	(Applying for federal Medicaid approval)	Case per discharge	Prospective case rates set using 1983 cost report data as base period for inpatient services on or after Feb. 1, 1985. System implemented by simultaneous conversion, not phased-in. --Uses Medicare DRG classification system with state-specific Medicaid weights; --Base year operating cost per discharge is adj. for inflation to state's FY beginning Oct. 1 by use of market basket index; weights are state-specific and price indicators complied from DRG Natl. Market Basket with regional adjustments; --Operating cost per discharge is standardized for case mix to produce a hospital representative cost for case, which is then multiplied by DRG relative weights [and adj. for budget neutrality] to obtain hospital-specific		Uncompensated Care $20 million set-aside to be distributed based on hospital's percentage of indigent volume. Each participating facility gets fixed parameter times their indigent volume as an add-on.	All readmissions within 7 days reviewed on prepayment basis.

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Capital and direct education costs reimbursed as prospective rate per case add-on; --Hospital-specific DRG prices adjusted for outliers if applicable: day outliers are > 7 ± 3 S.D. from mean; high-day outliers receive 60% per diem for marginal days and low-day outliers paid actual charges, not to exceed DRG rate; Note: DRG prices are 100% hospital-specific only from Feb. 1 to Oct. 1, 1985; Effective Oct. 1, 1985, DRG price per case will be blend of hospital-specific price and statewide price, at 2/3 and 1/3 respectively; On Oct. 1, 1986, ratio will change to 1/3 and 2/3; and On Oct. 1, 1987, DRG price will be 100% of single standardized price.			

MINNESOTA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					
	Mandatory budget review with voluntary compliance. Approves rate of increase and screens base costs through use of inter-hospital comparisons.	Blue Cross Commercial payers Self-pay	Charges	State Hospital Assoc. conducts budget review to identify problem areas for review and comment by external review panels. --Peer groups established through use of cluster analysis. --Hospital's costs analyzed for variance from average group cost per admission plus 15 functional cost categories; --Hospital must explain variances from peer group means; --State Hospital Assoc. determines inflation factor using Delphi panel method; --Although compliance is voluntary, BC contract limits reimbursement to approved rates.	Financial requirements.	Allows retroactive adjustments based on changes in volume and inflation. Case Mix No explicit adj. is made.	
1981	No change						
1982	Caps admissions cost increases at 8% [see below].						

MINNESOTA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1983 [Effec. 10/1/83]	Mandatory, prospective reimbursement system. Applies rate of increase controls. No peer group ceilings are used.	Medicaid 180 hospitals	Case per admission and/or per diem	Note: In anticipation of new system, cost increases were limited to no more than 8% for admissions from Jan. 1, 1982 - Dec. 31, 1982; and Each rate per admission and each rate per day reduced by 4% during period Jan. 1, 1983 - June 30, 1983. Sets prospective case/per diem rates based on hospital FY 1981, beginning with admissions on or after Oct. 1, 1983 as follows: --Pass-through costs are depreciation, interest, rents, malpractice insurance; --Remainder is allowable base year costs, trended forward by use of DRI Natl. Market Basket with Minn.-specific hospital weights, plus 1% for intensity. Note: Allowable base year costs limited to 5% increase for admissions for hospital Fiscal Years beginning on or after July 1, 1983 until July 28, 1985. --Hospitals with < 100 Medicaid admissions in rate year may receive per diem		Case Mix Mix changes are allowable criteria for rate appeals. Uncompensated Care If low income admissions >15%, percentage increase to rate calculated on sliding scale; beginning at 1/4 of 1% for each percentage point from 15-20%, up to 1% for each percentage point above 30%.	Prior authorization required for certain procedures. Second opinion required for certain elective surgical procedures.

MINNESOTA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1984	No change						
1985	Continues 5% cap until July 28, and eliminates 1% intensity factor as of July 1.						Prior authority required for all admissions except emergency and maternity.
[Effec. 8/1/85]	Will adopt new mandatory case mix system derived by compressing 467 Medicare DRGs into 36 "diagnostic categories."	(Applying for federal Medicaid approval)	Case per discharge	Using Wisconsin Medicaid-specific weights, categorical rate per admission set as follows: --Base year cost per admission is increased by inflation factor; --This rate is then multiplied by relative value of its diagnostic category; --Case rate is increased by value of pass-through costs for capital and education.			

MISSISSIPPI

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles	Medicaid					Limit of 20 days per fiscal year. No weekend admissions, except emergencies.
1981 [Effec. 7/1/81]	Mandatory prospective reimbursement system. Applies rate of increase controls together with peer group ceilings.	Medicaid 107 hospitals	Per diem	Prospective per diem rates based on latest cost report are calculated as follows: --Rates set July 1 include 3 components: operating, capital, and education costs; --Cannot exceed Medicare Sec. 223 limits; --Trend factor using latest sources from DRI Market Basket and Natl. Hosp. Input Price Index adjusted regionally is applied to operating and education costs, from midpoint of reporting period to midpoint of rate period; --If projected trend factor is above or below actual inflation rate by >1%, next rate will adjust for difference; --Costs are inflated to a common year end [12/31]; --Labor cost per diem adjusted by SMSA Wage Index; --Hospitals divided into 5 peer groups by bed size;	Based on Medicare, includes: routine operating ancillary Services capital education; Excludes: routine nursing differential	Due to major changes in case mix. Occupancy Capital costs adjusted based on sliding scale of specific occupancy levels: 0-50 beds 60% 51-100 beds 65% 101-150 beds 70% 151-200 beds 75% 201 + beds 80%	

MISSISSIPPI (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Adjusted labor cost plus non-labor cost per diem is arrayed from highest to lowest by class; --Operating costs are capped at 80th percentile.			
1982 [Effec. 7/1/82]						Uncompensated Care Class rate ceiling doesn´t apply if hospital adversely affected [i.e., operating cost >80th percentile], by serving high number of Medicaid inpatients [i.e., utilization at least 125% of state average].	
1983	No change						
1984 [Effec. 7/1/84]				Adjusted labor component for current year is compared to prior year, and lesser is included in per diem rate.			Reduced day limit to 15. Required prior authorization for all admissions except maternity. Eliminated one-day stays, except emergencies.
1985	No change						

MISSOURI

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					Limit of 21 days per admission.
1981 [Effec. 10/1/81]	Mandatory, prospective reimbursement system. Applies rate of increase controls. No peer group ceilings are used.	Medicaid 149 hospitals	Per diem	Prospective per diem is lower of each hospital's Medicare rate, prior year costs trended forward, or Medicaid costs 3 years prior trended each year to current rate year. --Base year is third prior hospital FY; rate year implemented each January or July depending on hospital FY; --Hospital's total allowable base year costs adjusted by Medicare 223 limits; --Base per diem trended for each of 3 prior FYs by Missouri-specific Hospital Market Basket Index plus 1% intensity; Index developed from National Hospital Input Price Index plus DRI regional forecasts; --Adjustment made if actual inflation differs from projected by >0.5% in either direction.	Based on Medicare; excludes: routine nursing differential	Appeals possible, based on substantial changes in case mix or discrepancies in Market Basket weights; or demonstrated financial distress due to level of uncompensated care costs.	Rescinded 21-day limit. Limits LOS to 75th percentile based on PAS diagnosis, unless medically justified. No weekend admissions, except emergencies. Requires second opinion for certain elective surgical procedures.

MISSOURI (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
	Non-legislated voluntary budget review and compliance.	Commercial payers Self-pay BC of K.C.					
1982							No coverage for procedures that could be on outpatient basis. One-day inpatient stays to be billed as outpatient services. Imposes $10 copay per nonemergency hospitalization.
1983 [Effec. 9/83]				1984 Market Basket Index revised as follows: --Only half of increase keyed to individual provider's per diem rate; --Other half applied to individual rate times average weighted per diem for all hospitals.			
1984							Prior authorization required for certain surgical procedures.
1985	No change						

MONTANA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retro-spective cost reimbursement principles.	Medicaid 60 hospitals					
1981	No change						
1982	No change						
1983	No change						
1984							Covers second opinions for surgery.
1985	No change						

NEBRASKA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					
1981	No change						
1982 [Effec. 7/1/82]	Mandatory, prospective reimbursement system. Applies rate of increase controls. Hospitals with <$25,000 in Medicaid billings in previous FY are paid Medicare rates. No peer group ceilings are used.	Medicaid 99 hospitals	Per diem	Prospective per diems based on prior year; rate year begins each July 1st. --Allowable base year costs minus capital costs are updated by DRI Natl. Market Basket; --Prospective rate is lesser of projected base rate plus allowed capital costs or projected current rate plus capital costs; --Upper limit based on customary charges and/or Medicare limit.	Based on Medicare, excludes: routine nursing differential	Case Mix No explicit adj. is made.	No coverage for admissions batteries of lab tests. Limits LOS to certain percentile based on PAS diagnosis, unless medically justified.
1983							Prior authorization required for certain specific procedures.
1984	No change						
1985	No change						

NEVADA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					
1981	No change						
1982							Prior authorization required for all admissions, except emergencies and maternity. Limited preoperative stays to one day.
1983 [Effec. 9/1/83]	Mandatory, prospective reimbursement system. Applies rate of increase controls, together with peer group ceilings.	Medicaid 24 hospitals	Case per admission for days 1-15; Per diem for days over 15.	Prospective case rates and per diems based on prior year's cost set for all admissions on or after 9/1/83 as follows: --Hospitals assigned to peer groups based on size, location, intensity, LOS, and cost per stay; --Base period [4/82 - 9/82] costs per admission averaged for 4 categories: general, maternity, newborn, and neonatal ICU; --Base rates per admission category based on lowest cost hospital in each group;	Same as Medicare.	<u>Uncompensated Care</u> Hospitals serving disproportionate number low-income patients [defined as >50%] are eligible for review and adjustment on case-by-case basis. Currently no Nevada hospitals qualify. <u>Case Mix</u> No explicit adj. is made.	

NEVADA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Base rates trended forward from middle of base period to end rate year by projected increases in All Items index in CPI-W or 1/2 of Medical Care Component of CPI-W, whichever is greater; --Rates adjusted for inflation semiannually on Jan. 1 and July 1 using similar estimates; --Rates can't exceed aggregate payments under Medicare limits.			
1984	No change						
1985 [Effec. 1/1/85]				Methodology for semiannual rate adjustement altered: --Base rates now updated from midpoint of base period to midpoint of each rate period by application of known percentage change in Medical Care Component of CPI-W, for an identical length of time.			

NEW HAMPSHIRE

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retro-spective cost reimbursement principles.	Medicaid 27 hospitals					
1981							Limits of 12 days per year.
1982							Removed 12-day limit; coverage criteria now is medical necessity with PSRO approval.
1983	No change						
1984	No change						
1985	No change						

NEW JERSEY

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Mandatory, prospective reimbursement system. (1) Existing SHARE system of budget review with negotiation or rate of increase control, option left to hospital. Budget review option employs sophisticated cost screens based on peer groups.	109 hospitals Medicaid Blue Cross	 Per diem	(1) Standard Hospital Accounting and Rate Evaluation or SHARE system Approximately half of hospitals elect to receive a "global rate" based on previous year's budget increased by economic factor reflecting inflation and intensity; Rate year is 1/1-12/1. Avoids detailed review.	N.J. cost allocation methods used; Excludes bad debts	(1) Volume Changes Adjustments made to rate if hospital's actual patient days differ from projections: --Ratios generally are 50% variable costs for personnel; 100% variable for supplies. Intensity Allowance "Intensity" defined as cost per admission in each cost center. No increase allowed for hospital departments over 110% ceiling of median costs; sliding scale of increases used below ceiling: Increase 100-110% +1% 90-100% +2% < 90% +3%	
[Effect. 1/1/80]	(2) New case mix system to be phased-in over 3-year period: implemented in 26 hospitals in 1980; 40 hospitals joined in 1981; and 43 in 1982. Controls total revenues. Applies peer group cost screens. Separate DRG prices set for each hospital based on unique operating characteristics, as well as group standards. Note: A hospital may appeal its rate, causing a detailed budget review to be performed. This alternative is seldom used.	All payers	Case per discharge	Remaining hospitals enter budget review system with 2-year lag in base, i.e., 1978 actual costs for 1980 rates. --3 levels of cost screens: total hospital, clusters of departments, individual departments; --Using 39 functional cost centers, following 3 clusters are formed: ancillary, general service, and inpatient care; --Clusters are screened at 110% of base-year costs; --For failing clusters, individual cost centers by department are screened by percentage of median cost for appropriate peer group;			

NEW JERSEY (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Hospitals usually allowed up to 110% of median cost, with some screens set at 20 to 50% above median depending on cost center; --3 types of classification systems used: (1) statewide peer groups used for many departments and all clusters; (2) categorical grouping by size, teaching status and function used for other departments; or (3) area character grouping by geographic location. --After screening, an economic trend factor is applied, based on non-hospital indices such as CPI, WPI, and Northeast Employment Cost Index; --Factor adjusted for actual costs; --Capital costs and malpractice insurance are pass-through items.			

NEW JERSEY (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				(2) Case Mix System Sets a per-case payment rate specific to each type of patient using DRG method [AUTOGAP, developed at Yale, producing 383 DRG categories]. 1978 is base year for calendar rate year 1980. Inpatient costs are clustered into 3 categories: direct patient care, indirect, and general service: --General service costs allocated to direct/indirect centers using step-down; --Direct patient care costs apportioned to DRGs based on patient days for routine services, and on ratio of charges to charges applied to cost [RCCAC] for ancillary services; --Direct patient care costs per DRG are averaged separately across all patients in teaching, minor teaching, and non-teaching facilities, producing an "incentive standard" for each group; --Each hospital's DRG rate is a blend of	Includes: bad debt charity care working capital	(2) Uncompensated Care Hospitals receive full payment for all uncompensated care; cost apportioned among all payers. Capital Facility Formula Allowance provides funds for replacement/renovation at 20% of current replacement costs. New Incentive Allowance Hospital that accepts its rates and forgoes an appeal will have 1% added to its direct patient care costs to offset cost of any improvements.	

NEW JERSEY (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				its own average cost per DRG and its mean group incentive standard; the split is roughly 50-50, with slightly different breakdowns possible on a case-by-case basis; --Resulting figures are adjusted for inflation from base through rate year using N.J.'s composite index, which includes a hospital-specific equalization factor for labor costs; --Next, indirect costs are divided by direct patient care costs, and ranked by teaching/minor teaching/non-teaching groups; portion >110% of median rates is excluded from allowable cost base; --Adjusted direct and indirect costs are combined with uninflated elements like working capital costs and uncompensated care; result is multiplied by projected volume to yield approved budget; --Hospitals structure charges so revenues collected equal budget; --Any over or under collection plus			

NEW JERSEY (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1981							Limits weekend admissions to emergencies only.
1982				First use of new set of DRGs with 467 groups.			Second opinion required for certain elective surgical procedures.
1983				--Switched to DRI Natl. Market Basket for input weights; uses some hospital-specific price proxies.		Combined Volume/ Intensity Adjustment N.J. system is partially volume variable; pays variable/fixed costs on a sliding scale. Exact percentage determined based on degree and direction of volume changes.	Prior authorization required for certain specific procedures.
1984	Rates for 1984 will be based on 1982 costs adj. for inflation.			DRG system was rebased using 1982 data, and using 467 diagnostic categories. Refined methodology regarding "outlier" cases (which had been paid "controlled charges" for actual services instead of DRG rates in the past) as follows:			

NEW JERSEY (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--High LOS are paid DRG rate per case plus modified per diem; --Low LOS are paid per diem only; --Low volume DRGs paid standard rate per case.			
1985	No change						

NEW MEXICO

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid 42 hospitals					Prior authorization required for certain specific procedures.
1981	No change						
1982	No change						
1983							PSRO reviews all stays above 50th percentile by PAS diagnosis.
1984	No change						
1985	Would continue applying Medicare target rate limits, subject to pending state plan amendments. Note: Proposed revisions are interim measures, pending future development of a prospective system.			Awaiting HCFA approval on following exceptions: --Would lower Medicare target rate per discharge to 105% of peer group mean effective Jan. 1, 1985; --Would exempt Pediatric Intensive Care Units and burn units from target rate limits.		Case Mix No explicit adj. is made.	

NEW YORK

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Mandatory, prospective reimbursement system.	275 hospitals					
	Applies rate of increase controls together with screening of base year costs by peer group.	Medicaid Blue Cross	Per diem	Under Medicaid Prospective per diems set for a universal rate year beginning January 1, with base year defined as 2 years prior.	Based on Medicare; Excludes: 10% of intern and resident costs.	Minimum Occupancy Occupancy below minimum levels lowers per diem rate as projected patient days at that level are substituted for actual days: Urban / Rural Med/Surg. 85% / 80% Pediatric 75% / 70% Maternity 60% / 60% Volume Adj. Changes of < 5% in total days result in automatic adjustment. Capital costs are considered 100% fixed; operating costs split 80% fixed/20% variable. Changes > 5% require case-by-case review. Case Mix Uses DRG-weighted indices for patient days, discharges and LOS within the appeals process only; e.g., if hospital has 20% more complex case mix, then 20% of ceiling penalty disallowance on routine cost per diem is reinstated.	N.Y. State offers increased rates as incentives to reduce unnecessary beds; encourage closings/mergers; and convert acute beds. Increases are temporary; reflect associated staffing and/or conversion costs.
	For charge payers hospitals must accept lower of trend factor or actual increase. Costs apportioned among payers according to each facility's average costs per diem.	Commercial Self-pay	Charges	Rates based on actual base year costs, analyzed by peer group comparisons. --Grouping methodology used is seed clustering, based on such variables as case and service mix, size, location and teaching status. Each hospital is at center of its own group. Formula calculates rates as follows: --Each hospital's routine costs per patient day [adjusted for geog. differences in wages] and ancillary costs per discharge are screened against its peers, and costs in excess of 105% of group mean are disallowed;			

NEW YORK (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Average length of stay [ALOS] compared to group´s ALOS plus one day, and excessive LOS penalty applied if appropriate: [Excess Days] X [Total Discharges] X [Lower of Hospital´s or group´s routine Per Diem] = Total Dollar Disallowance. --LOS standards take into account each hospital´s case mix; --Allowable routine, ancillary and education costs are added and trended forward to rate year, generally using external indices such as CPI, WPI, and BLS wage increase data; --Each hospital gets group-specific inflation rate; NOTE: For purposes of calculating trend factor only, N.Y. divides hospitals into 13 groups based on geographic location, teaching status, population, and ownership. --Capital costs including historical cost depreciation are passed-through; --Allows retroactive adj. for actual costs;		Uncompensated Care No specific provisions. However, an Emergency Reimbursement Program can provide funds to financially troubled inner-city hospitals serving large numbers of indigents. Intended as bridge mechanism to forestall bankruptcy only.	

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Total inpatient cost is divided by patient days, adjusted for minimum occupancy levels by service, to determine per diem rate.			
				Under Blue Cross BC rates are set by either downstate system [N.Y.C. area] or upstate system [remainder of state]. --BC per diem rates employ Medicaid trend factor and grouping system, as well as LOS and minimum utilization penalties. --Major difference with Medicaid is in screening of base year costs. BC combines routine, ancillary and LOS penalties into one penalty. Yields an overall group average cost per discharge ceiling: Six upstate BC plans use 100% of mean as ceiling; downstate BC uses 102% of average. --Allows retroactive adj. for actual variance in economic factors.	Similar to Medicaid; except BC inpatient per diem must include its portion of any net loss in non-referred ambulatory and ER services. Also, BC pays some capital needs in excess of depreciation and interest.	Same minimum utilization penalties as Medicaid.	Same closure/conversion programs as Medicaid.
				Under Charge-Based Charges may increase by amount of Medicaid trend factor, adj. for actual costs.		Appeals allowed for significant volume changes or changes in types of services.	

NEW YORK (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1981							No payment for procedures that could be on outpatient basis.
1982	Now costs are apportioned among payers using ratio of costs to charges methodology.					Volume Adjustment Total inpatient days in base year is target volume. If actual days > target, hospital paid predetermined percentage of its rate for each excess day to cover variable costs; for decreases, hospital receives appropriate fixed costs only. Actual ratio of fixed/variable costs fluctuates according to type and degree of volume change, i.e., change in discharges vs. change in LOS.	Preoperative stay limited to 1 day except by prior auth.
1983 [Effec. 1/1/83]	Major revision of prospective formula system. Controls total inpatient revenue and sets individual hospital revenue caps with guaranteed revenue floors. Continues rate of increase controls with screens on base year costs.	242 hospitals All payers: Medicaid Blue Cross Commercial Self-pay Medicare [3-year wavier]	Average cost per day for routine costs/ ratio of costs to charges for ancillary costs	Hospital-specific revenue caps computed on 3-year cycle. 1981 allowable costs trended forward serve as base year for 1983 rates. For 1984, rates based on 1983 authorized revenues adjusted upward; same process for 1985. Hospitals may keep difference below authorized revenues.	Includes payment for some bad debts and charity care, as described below. Malpractice insurance costs to be phased-in until 1985, when two-thirds of level will be derived from Medicare principles, and	Minimum Occupancy Standards as adjusted allow a corridor of 5 beds or 1% of certified beds, whichever is greater: Urban / Rural MedSur. 85% / 80% Ped. 70% / 70% Matern. 60% or 500 live births / 75% or 1,500 live births	Total number of days per year limited by PSRO or state designee based on medical necessity/ appropriateness. Second opinion required for certain

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
	All payers contribute to facility´s allowed revenue based on their share of charges. Overall ceiling limits increases in hospital inpatient charges to level of trend factor multiplied by RCC for each payer.			--New ancillary services reimbursement ceiling set at 105% of peer group average costs per discharge; --New combined routine/LOS ceiling is set at 107.5% of peer group average costs per day, using expected days (based on the hospital´s LOS standard) rather than actual days; --Puts transitional cap on total dollar disallowances by region: to be based on adjusted 1982 disallowances as a percentage of operating costs; --Unrestricted 1% discretionary allowance added to 1983 rates; for 1984-1985 size of allowance to be determined and restricted to non-operational uses. Under Medicare Waiver Rate of increase must not exceed national average. Only 25% of disallowances due to efficiency standards applicable in 1983; up to 50% in 1984 and 75% in 1985.	one-third according to N.Y. method.	Volume Adj. Continued from previous year. Uncompensated Care Each payer adds factor to its rate to create regional pool of funds earmarked for bad debt/charity care: --Separate pools for public and voluntary/proprietary hospitals; --Eligibility for allowance based on need, continuity of care to indigent, and efficiency in obtaining claims due; --Statewide pool in 1983 equals 2% statewide reimbursable costs, 3% in 1984 and 4% in 1985; --Estimated 1983 relief to voluntary/proprietaries is 38 cents per $1.00 unreimbursed; --Added pool resources available regionally to assist financially distressed hospitals serving indigent; --Medicare´s share limited to ratio of inpatient charges to total inpatient/outpatient charges;	elective sugical procedures.

NEW YORK (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				Charge-Based Payers Differential between BC and commericals/ self-pay can be no more than 12% by 1986.		--New regional pool aids voluntary/pro-prietaries negatively impacted by Medicare transition to prospective reimbursement. Case Mix Will introduce automatic case mix adj. to rate to recognize differences in case mix between hospital and peer group it is compared to for ceiling purposes starting on Jan. 1, 1986. Methodology will be based on same 467 DRG system used by Medicare.	
1984	Beginning 1/1/84, a hospital's average charge per diem is limited to no more than a fixed percentage above its Blue Cross rate, i.e., 12%.			--Discretionary allowance add-on increased from 1 to 2% for all hospitals. --Capital costs no longer passed through; are included in rates on a budget basis.			
1985	N.Y. will not apply for an extension of Medicare waiver beyond its expiration date of 12/31/85.			--Discretionary add-on increased to 3% for public general hospitals.			

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles	Medicaid					
1981 [Effec. 11/1/81]	Mandatory, prospective reimbursement system. Applies rate of increase controls to base year. No peer group ceilings are used.	Medicaid 132 hospitals	Per diem	Sets prospective per diem rates annually beginning July 1. Initial base year is hospital FY 1981 and is fixed. --Rate is sum of capital and operating rate components; cannot exceed Medicare Sec. 223 routine limits. --Capital component is higher of base-year capital cost per diem or most recent capital rate; --Operating component derived by inflating base-year operating cost; --Inflation index based on DRI National Hospital Market Basket adjusted for North Carolina inflation + 2% intensity allowance.	Based on Medicare, includes: routine operating ancillary services cost capital education	Uncompensated Care Appeals allowed if rate deemed inadequate due to increase in Medicaid patient mix since base year. Case Mix No explicit adj. is made.	Prior authorization required for certain specific procedures.
1982 [Effec. 7/1/82]				--Intensity allowance reduced to 1%; --Hospitals with rates at or below all-hospital mean will be reimbursed at full rate without day limits; --Hospitals with rates > mean will be			

NORTH CAROLINA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				reimbursed at full rate up to annual days limit; then days in excess of limit (defined as 85% of 1981 days) will be paid at mean rate of hospitals below all-hospital mean.			
1983	No change						
1984	No change						
1985	No change						

NORTH DAKOTA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid 53 hospitals					No coverage for weekend admissions, except emergencies.
1981	No change						
1982	No change						
1983	No change						
1984	No change						
1985	No change						

OHIO

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					Limit of 60 days per spell of illness.
1981	No change						
1982							Tightened limit to 30 days per spell of illness, with exceptions if medically necessary.
1983	No change						
1984 [Effec. 10/1/84]	Mandatory, prospective reimbursement system. Employs case mix system based on DRGs. Applies peer group ceilings.	Medicaid 203 hospitals	Case per discharge	Prospective rates per case set using CY 1982 as base year; all hospitals brought into system at same time, i.e., 10/1/84. Future rate years will coincide with each hospital's FY. --Ohio uses Medicare DRG classification system, with Ohio-specific relative weights; --Base year cost per case adjusted for such factors as wages, education, malpractice insur., and case mix; and a hospital-specific average cost per discharge is calculated;	Based on Medicare	Volume Changes Average cost per discharge is reduced by .5% to account for shifts in number of admissions. Uncompensated Care Special appeal on case-by-case basis for hospitals with financial distress related to serving greater than average percentage publically funded patients.	Prior authorization required for most elective hospital admissions.

OHIO (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--14 peer groups are determined by location/wage rate, bed size, teaching activity, service exclusivity; --Next, an unadjusted peer group average cost per discharge is calculated; --System phased-in over 3 years by blending hospital-specific average cost per discharge with peer group average in declining proportions: 50/50 for FY 1985 25/75 for FY 1986 0/100 for FY 1987; --These average cost per discharge components are updated using DRI Natl. Market Basket for 1983/1984; for 1985 DRI to project Ohio regional hospital market basket; --If actual inflation differs, adj. is made to next rate period; Note: For first rate year a 7.5% statewide cap on rate of growth for inpatient expenditures is in effect;			

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Also, average cost per discharge component is reduced 3.38% to account for improved accuracy in coding; and reduced by factor to account for unanticipated payments for outlier cases; --When fully implemented, final prospective payment amount will equal: Average Cost Per Discharge Amount by Peer Group X DRG Relative Weight X Add-Ons for Teaching/ Wage Costs in Teaching Hospitals X Capital Allowance			
	Non-legislated voluntary budget review and compliance.	Blue Cross Commercial Payers Self-Pay					
1985	No change						

OKLAHOMA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					Limit of 10 days per admission.
1981	No change						
1982	No change						
1983 [Effec. 11/1/83]	Mandatory, prospective reimbursement system. Applies rate of increase controls. No peer group ceilings are used.	Medicaid 120 hospitals	Per diem	Prospective per diems based on hospital FY ending 6/30/81 or 6/30/82, whichever is lower, with universal rate year Jan. 1st, are calculated as follows: --Allowable base costs trended forward using DRI Natl. Market Basket; --Prospective rates for CY 1984-1985 can't be less than plan in effect prior to 11/1/83.	Based on Medicare.	Case Mix If case mix changes significantly in rate year, rate is redetermined by adjusting base period cost to reflect rate year's case mix.	No readmissions permitted within 20 days of discharge; exceptions on case-by-case basis.
1984							Prior authorization required for certain procedures that could be on outpatient basis.
1985	No change						

OREGON

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid			Based on Medicare; excludes: routine nursing differential		
	Mandatory budget review, but voluntary compliance.	Blue Cross Commercial payers Self-pay	Charges	State Health Planning and Development Agency reviews budgets by cost centers; considers factors like inflation, volume changes. Publicizes rates deemed unreasonable.			
1981							Reduced day limits from 21 to 18 per year. Required prior authorization for over 800 elective surgical procedures. Eliminated coverage for nonessential surgery, lab and X-rays.
1982	No change						
1983 [Effec. 7/15/83]	Mandatory, prospective reimbursement system. Applies rate of increase controls. No peer group ceilings are used.	Medicaid 74 hospitals	Case per discharge	Sets hospital-specific flat average rate per discharge beginning with admissions on 7/15/83; fixed base year is state's FY from 7/1/80 - 6/30/81. Each hospital's cost per discharge in FY 1981 updated as follows:		Uncompensated Care Facilities disadvantaged by low-income patient load can have rates increased accordingly. State found no relationship between cost and low-income patient load through 12/83.	

OREGON (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--From midpoint of hospital's FY 1981 to end of FY 1982 [6/82] by actual increase in inpatient cost per user; --From 7/82 to 9/83 by inflation factor based on DRI Natl. Market Basket with Oregon-specific labor component; --Estimates for future period will be based on statewide econometric model and may be higher than Oregon Market Basket; --Aggregate rates can't exceed Medicare limits.		Case Mix No explicit adj. is made.	
1984							Prior authorization required for all admissions, except maternity and emergency. Instituted mandatory second opinion for surgery.
1985	Plans to implement case mix system based on DRGs on or after July 1. Several hospitals to test new system earlier in CY 1985, in conjunction with existing system.	(Applying for federal Medicaid approval)	Case per discharge	--A single, statewide base reimbursement rate per DRG would be paid to hospitals using Medicare DRG categories and weights.			

PENNSYLVANIA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					
1981	No change						
1982	Applied overall cap on allowable cost increases under existing retrospective system.	Medicaid 244 hospitals	Per diem	Limited rate of increase in hospital per diem to 10% from 7/1/82 to 7/1/83.			No coverage for procedures that could be on outpatient basis.
1983				Limited rate of increase in hospital per diem to 8% from 7/1/83 to 7/1/84.			No payment for weekend admissions unless surgery performed within one day.
1984 [Effec. 7/1/84]	Mandatory, prospective reimbursement system. Established case mix system based on DRG groupings. Applies peer group ceilings.	Medicaid	Case per discharge	Prospective case rates based on paid claims data for two most recently ended calendar years, i.e., base is FY 1982-1983 for hospital FY 1984. --Employs Medicare DRG classification system to develop DRG relative value scale with Medicaid-specific weights for Pennsylvania; --Following costs are excluded from DRG rate calculations and paid separately: depreciation and interest, direct education, MD services, outliers; costs for first two categories are inflated	Based on Medicare.		If readmission to hospital within 7 days is related to first admission, Medicaid makes no payment in addition to original DRG payment. Requires $3 copayment for each day in hospital, up to $21 for one stay.

PENNSYLVANIA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				to prospective rate year using DRI Natl. Market Basket; --Peer grouping system ranks all hospitals according to criteria under each of following 4 categories: teaching status, Medicaid volume, environmental characteristics, and hospital costs; --Next, each hospital's composite per diem rate is calculated based on average per diems for each of 4 categories into which it was placed; --Ranked array of composite per diem rates is divided into 8 equal groups, four above median and four below; --Each hospital's average cost per case updated from preceding FY to end of prospective rate year using DRI Natl. Market Basket. [If actual increase is < Market Basket, hospital case rate is increased by half the difference;			

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Hospital's average cost per case standardized to account for case mix by its own case mix index; --For FY 1984-1985, final payment rate for discharged patient is equal to 75% of hospital's specific cost per case multiplied by DRG relative value plus 25% of hospital's group average cost per case multiplied by relative value; --For FY 1985-1986, payment rate blend is altered to include 50% of hospital's specific cost per case plus 50% of hospital's group average cost per case; --For FY 1986-1987, payment rate will be based wholly on hospital's group average cost per case.			
1985	No change						

RHODE ISLAND

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Mandatory, prospective reimbursement system. Budget negotiations set an overall ceiling or "Maxicap" for total hospital expenditures statewide. Hospitals also required to negotiate individual budgets. No peer group ceilings applied. Participating payers reimburse facilities based on their share of charges.	Medicaid Blue Cross 16 hospitals	Global: Percentage of charges	--Base year is prior year, with universal rate year beginning Oct. 1; --Statewide inflation factor is set annually based on CPI, WPI and local price factors; --Budget review conducted on global and cost-center levels; hospitals grouped by HAS data, but comparisons limited; --After total operating expenses negotiated, each hospital sets a schedule of charges designed to stay within approved budget revenues; --Sum of individual hospital expenses may not exceed "Maxicap."	Based on Medicare; except bad debts and charity care are excluded.	Technology Statewide medical program review process to assess appropriateness of new or expanded services. Funding based on priority of need and affordability. Volume Specific corridors determine percentage of routine costs which can be retained by hospital when increases/decreases occur in budgeted levels. Hospitals can keep 35% of ancillary services revenue above negotiated base; 65% of revenues from decreased ancillary volume. If volume increases or decreases by > 10%, hospital must renegotiate revenues. Case Mix An adj. is possible for major changes in case mix.	Prior authorization required for stays in excess of 15 days per admission for persons under 65; or above 60 days for dual eligibles over 65.
1981	No change						

RHODE ISLAND (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1982							No coverage for procedures that could be on outpatient basis.
1983							Prior authorization required for administratively necessary days.
1984 [Effec. 10/1/84]							Established statewide cap on capital costs through CON program. Each hospital's proposal ranked by "needs and affordability test"; monies allocated up to cap.
1985	No change						

SOUTH CAROLINA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid 71 hospitals					Prior authorization required for certain specific procedures.
1981							Lowered day limit from 40 to 18 days per fiscal year.
1982							Lowered day limit from 18 to 12 days per fiscal year.
1983	No change						
1984							Increased day limit for EPSDT recipients from 12 to 28 days per fiscal year.
1985							Increased day limit for EPSDT recipients from 28 to 60 days per fiscal year.

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					Increased day limits from 30 to 60 days per benefit period [effec. 7/80].
1981	No change						
1982	No change						
1983							Reduced day limits from 60 to 30 days per benefit period [effec. 1/83]. Removed all day limits [effec. 7/83]. Imposed $25 co-payment on all nonemergency admissions.
1984	No change						
1985 [Effec. 1/1/85]	Established a prospective reimbursement system. Employs a case mix system based on DRGs. No peer group ceilings are used. Note: South Dakota's Medicaid program is still officially considered a traditional retrospective one until it receives a waiver from HCFA.	(Applying for federal Medicaid approval) 65 hospitals	Case per discharge	Prospective case payments based on most recent audited costs, updated to 12/31/84. --Employs Medicare DRG weights to develop Medicaid-specific rates; --Employs hospital-specific case mix index, and facilities with low Medicaid utilization [defined as fewer than 30 Medicaid discharges annually] are grouped to compute one index and payment amount.	Based on Medicare		

SOUTH DAKOTA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Hospitals with > 30 Medicaid discharges per year can receive 100% hospital-specific average cost per case; --Capital and education costs added to approved operating costs; --State negotiates with hospitals to select update factor used each July; --Medicare principles used to compute day and cost outliers.			

TENNESSEE

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles	Medicaid					Limit of 20 days per fiscal year.
1981							Reduced covered hospital days to 14. No weekend admissions except emergencies.
1982							Prior authorization required for certain specific procedures No coverage for procedures that could be on outpatient basis.
1983 [Effec. 10/1/83]	Mandatory, prospective reimbursement system. Applies rate of increase controls to base year. No peer group ceilings are used. Note: Hospitals with <$5,000 annually in Medicaid charges may choose to be exempt. Such providers will be paid up to 80% of reasonable charges. Involves only handful of facilities.	Medicaid 146 hospitals	Per diem	Prospective per diems calculated as follows: --Initial rate year begins on or after 10/1/83 depending on hospital's fiscal year; fixed base year is 12 months prior; --Costs separated into operating and pass-through components; --Operating costs from midpoint of base year to midpoint of cost reporting period preceding rate year are trended forward by actual rate of increase in Medicare costs;	Based on Medicare, includes: routine operating ancillary services capital education	Minimum Occupancy Capital costs adjusted annually based on minimum levels required: 100 beds or less - 60% >100 beds - 70% Education Costs Adjustment granted to teaching facilities based on ratio of residents and interns to total beds. Uncompensated Care Hospitals serving low-income patients eligible for payment incentive not to exceed 10% as follows:	

TENNESSEE (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Thereafter, trend factor used is estimated DRI Natl. Hosp. Market Basket plus 1% for intensity; --Rate is sum of trended operating components plus untrended pass-through component [i.e., capital, education, hospital-based physician costs, and return on equity].		--Rate increased 1% per 1% increment in utilization above 8%; OR --Rate increased 1% per 1,000 Medicaid days over 3,000, whichever is greater. Case Mix Adj. Available for significant changes in case mix resulting in 5% change in per diem rate or $25,000 impact on Medicaid payments.	
1984 [Effec. 3/84]							Increases day limitation for recipients under 21 to 20. Requires second opinion for 5 elective surgical procedures.
1985	No change						

TEXAS

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid 495 hospitals					Limit of 30 days per spell of illness.
1981	No change						
1982	No change						
1983	No change						
1984	No change						
1985	Currently developing a prospective system which would make fixed payments per type of Medicaid discharge according to DRGs or state-developed classification of illness categories. Target implementation date is July 1986.						

UTAH

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					
1981							Limit of 28 days per stay.
1982							Eliminated 28-days-per-stay limit in favor of new system: Authorized days for most frequent single causes of admission limited to 50th percentile ALOS set by PAS or state; exceptions must be medically justified. Prior authorization required for all elective surgical procedures which could be on outpatient basis.
1983 [Effec. 7/1/83]	Mandatory, prospective reimbursement system. Applies case mix system based on DRGs. No peer group ceilings are used.	Medicaid 37 hospitals	Case per discharge	Prospective rates per case set effective July 1983 by hospital FY. Fixed base year is prior 12 months. DRG-based system draws extensively upon Medicare PPS system: --Uses Medicare DRG classification system, and related case mix weights based on Medicare weights;	Based on Medicare		Prior authorization required for certain specific procedures. Deleted day hospital coverage.

UTAH (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Medicaid base costs are inflated based on a negotiated factor for anticipated economic trends/conditions; --Capital and direct education costs passed-through; --Both urban and rural hospitals paid same DRG fee plus pass-throughs;			
				--If actual costs are < DRG target rate, state pays costs plus 10% up to target rate; --If actual cost ≥ target rate, state pays target rate only, until provider costs are 60% above level, then pays 60% of additional provider costs; --Methodology assures minimum payment of 60% of billed charges, and limits maximum payment to 110% of billed charges for each eligible patient;			

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Uses Medicare methodology for day outliers, but doesn´t recognize cost outliers; --Aggregate payments can´t exceed Medicare limits.			
1984 [Effec. 10/1/84]				When Medicaid patient is eligible for only part of stay, hospital will be able to bill full charges for services during ineligible days.			Hospitals under DRG system aren´t held to 50th percentile LOS limit. Second admission within 7 days isn´t covered.
1985	State expects to develop a state-specific pricing system based on experience with ongoing prospective rate program.						

VERMONT

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid					
1981	No change						
1982							Prior authorization required for certain specific procedures.
1983 [Effec. 10/1/83]	Mandatory, prospective reimbursement system. Applies rate of increase controls subject to state's overall Medicaid appropriation. No peer group ceilings are used.	16 hospitals Medicaid	Per diem	Universal rate year is July 1. Prospective per diem based on prior year's allowable costs calculated as follows: --Each facility receives an increase (or decrease) based on ratio of its Medicaid charges during base year to state-appropriated funds in rate year; --During rate year 1984, hospital per diem costs were reduced by approx. 10% due to lower state appropriations.	Based on Medicare.	Case Mix No explicit adj. is made.	
1984				--Same cost formula of Medicaid charges divided by available funds is expected to result in a general hospital payment increase of 2-3% for July 1, 1984 - June 30, 1985.			
1985	No change						

VIRGINIA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles. Mandatory budget review, but voluntary compliance.	103 hospitals Medicaid Commercial Payers Self-pay	Charges	Relatively informal rate review process which emphasizes exceptional cases. Commission findings can be published.			Limit of 14 days per admission, with extensions up to 21 days if medically justified.
1981	No change						
1982	Mandatory, prospective reimbursement system. Applies rate of increase controls, together with peer group ceilings.	Medicaid	Per diem	Prospective rates set based on most recent cost data for CY 1981; rate year begins July 1, 1982 by hospital FY. --Hospitals classified by size and location into 7 peer groups; --Operating costs updated to July 1 using CPI 12-month average; --Operating costs standardized using SMSA wage indices, and a median is determined for each group; --Medians set an actual cost ceiling for each SMSA; each hospital grouping has series of ceilings representing one of each SMSA area;	Based on Medicare, excludes routine nursing differential	Uncompensated Care Hospital with Medicaid volume > 8% of total days receives adj. set at a percentage added to ceiling for each percentage of utilization up to 30%. Case Mix No explicit adj. is made.	Limits LOS to 75th percentile based on PAS diagnosis, up to maximum of 21 days per admission. No coverage for weekend admissions except emergencies. Limits preoperative hospital days to 1. Imposes copayment on medically needy of $30 per admission.

VIRGINIA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--No retrospective adj. is made; --Capital and education costs passed-through; --Hospitals below ceilings eligible for incentive paid on sliding scale, one for one, up to 25% of difference between allowable operating costs and appropriate per diem group ceiling.			
1983	No change						
1984							Changed day limit to 21 per spell of illness or admission. No coverage for certain procedures that could be on outpatient basis. Mandatory second opinion program for certain elective surgical procedures.
1985	No change						

WASHINGTON

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Mandatory, prospective reimbursement system. Controls total revenues. Budget review and negotiation system; applies base year screens to determine allowable costs, together with peer group ceilings.	115 hospitals All payers [Medicare/ Medicaid on experimental waivers.]	All hospitals assigned on random basis to one of three payment groups: Type I receive annual % of total budget revenues; Type II receive % of billed charges; Type III "retrospective control group" paid costs by Medicaid, Medicare, BC; paid charges by commercials, self-pay.	Commission determines allowable revenue as follows: --Base year is hospital's prior fiscal year; rate year is projected budget period; --Hospitals classified into 5 peer groups and 1 specialty group using cluster analysis; --Operating budget reviewed on global level using primary screens [e.g., per diem, % change], expenses at or below 70th percentile approved; --Secondary screening for failed facilities is at each of 10 cost centers, using same cutoff; --Unless hospital justifies excess expenses over 70th percentile, these amounts disallowed; --Total revenue is sum of allowable rate per unit of service [e.g., patient day, EKG] in each revenue center; hospital uses approved rates to establish list of charges. --Once total revenues are determined, payment rates are calculated depending on the hospital's reimbursement group: Type I, II, or III.	Financial requirements, including: operating costs education bad debts charity care capital component.	Inflation No inflation index is directly applied; assumes submitted budgets factor in increases in input prices. Volume Changes Revenues for Types II and III payment groups are volume-adjusted: Group — Fixed/Variable Ratio <60 beds — 80/20 >60<200 — 70/30 teaching — 60/40 Case Mix No explicit adj. is made.	

WASHINGTON (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1981	No change						
1982 [Effec. 7/1/82]		Medicaid	Percentage of charges.	Altered payment methodology as follows: --Rates established at ratio of approved operating expense [less any salary and wage component adjustments] to total approved revenues; --This ratio applied to charges determines maximum allowable payment; --Overall ceiling is customary charges or Medicare limits.	No effect on coverage of hospitals serving disproportionate share.	Wage Component Limitation Plan Hospitals reimbursed for wages/salaries of FTEs at lesser of their actual levels or percentage experienced during prior fiscal year.	Prior authorization required for non-emergency admissions. All other admissions require prepayment review. Requires second opinion for certain elected surgical procedures. Limits LOS to 75th percentile by PAS diagnosis, unless medically necessary.
Effec. 12/15/82				Operating expenses no longer adjusted by Wage Component Limitation Plan.			
1983							Lowered LOS limits from 75th to 50th percentile.
1984	No change						
1985 [Effec. 1/1/85]	Mandatory, prospective reimbursement system. Controls total revenues.	Program design calls for all payers. [applying for Medicare waiver]	Case per discharge	Maximum payable amount per case determined as follows: --Fixed base period is same as Medicare PPS, FY1982-FY1983;	Total financial requirements.		

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
	Sets hospital-specific rates according to DRG-based payment system. No peer group ceilings applied.			rates effective for discharges related to admissions on or after 1/1/85; --Employs same DRG-classifications and relative value weights as Medicare; --Applies these to state discharges in each DRG from 1981-1983 to derive case mix index for each hospital; --Average cost per discharge separated into operating, capital and teaching cost components; --Average cost per Medicaid patient is determined by adding case mix-adjusted cost per case for each component, updated for inflation; --Operating costs per discharge are inflated to payment period by DRI National Market Basket and 1% for technology; --Capital/teaching costs per discharge are essentially based on historical costs and passed-through; --Payment rates can't exceed customary charges.		Outliers High-cost cases paid at 80% of actual costs; Cost outliers defined as case which exceeds 1.5 times basic DRG payment or $12,000, whichever greater.	

WEST VIRGINIA

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retrospective cost reimbursement principles.	Medicaid 65 hospitals					Limit of 60 days per fiscal year.
	Mandatory disclosure of hospital financial data, but voluntary compliance with state findings.	All hospitals over 15 beds are to participate.		Without a formal budget review process, state may make determinations as to whether a hospital's rates are economically justified.			
1981							Reduced day limit from 60 to 30 days per fiscal year.
1982							Reduced day limit from 30 to 20 days per fiscal year.
1983							Mandatory second opinion program for certain elective surgical procedures.
1984	Continues to follow Medicare principles, with minor exception of TEFRA incentive award provisions.	Medicaid					
[Effec. 7/1/84]	Mandatory, prospective reimbursement system. Applies rate of increase controls. No peer group ceilings are used.	Blue Cross Commercial Payers Self-pay	Charges	Sets gross patient revenue cap by hospital FY effective July 1, 1984, using prior 9 months actual cost data plus 3 months projected data.	Financial requirements.	Volume Changes Using prior year's volume as target, adjusts for additional costs of excess days by 50/50 fixed/variable ratio.	

WEST VIRGINIA (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
	Sets limit on gross patient revenues for each hospital. Note: Medicare/ Medicaid expenses are carved out of allowable base costs; there is no direct or indirect effect on public beneficiaries.			--Allowable base year costs updated by DRI Natl. Market Basket with regional adjustments; --Capital-related education and malpractice costs also included in expense base; --Adjusted for actual inflation experience.		Uncompensated Care Recognizes these costs by building into base year expenses the actual level of uncompensated care costs. Case Mix No explicit adj. is made.	
1985	Currently developing a new prospective system based on case mix using Medicare DRG classifications. Weighting factors to be used undetermined. Proposed start date is 1/1/86.	Program design calls for all payers [Will apply for Medicaid/ Medicare waivers.]	Case per discharge	In first year of proposed case system, DRG rate will be hospital-specific average cost per discharge; in second year it becomes peer group average DRG cost. Would drop DRI index in favor of inflation update by hospital-specific price experience.		Volume Changes Methodology under development. Uncompensated Care Methodology under development.	

WISCONSIN

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Mandatory, prospective reimbursement system. Approves total revenues. Budget review and negotiation system. No peer group ceilings are applied.	146 hospitals Medicaid Blue Cross Commercial Payers Self-pay	Per diem Percentage of charges	Budget review process begins upon request for rate increase, which is limited to one per FY and usually coincides with start of hospital FY. --Rate Review Committee compares current request with hospital´s prior experience and with its peers; groupings based on geographic location, size and teaching activity; --Items analyzed include LOS, occupancy, revenue per diem, expenses per diem, charge per admission; --Comparisons don´t produce automatic limits; hospital given chance to justify above-average costs; --Committee-approved revenue target apportioned among payers and used to determine specific charges; --No retroactive adjustments made to Medicaid per diem.	All payers except Medicaid define financial requirements as set forth by AHA.	Volume Although volume changes considered in determining reasonableness of proposed budget, hospitals may keep excess revenues due to volume increases. Case Mix No explicit adj. is made.	Prior authorization required for certain specific procedures.
1981 [Effec. 4/1/81]	Adopted new retrospective reimbursement system. Applies rate of increase controls. No peer group ceilings are used.	Medicaid	Case per discharge at final settlement	Payment system phased-in beginning April 1 according to hospital FY; fixed base period is prior 12 months.	Based on Medicare; excludes indirect education costs	Volume Changes Adjusts rate per discharge if volume differs from base year:	Required second opinion for certain elective surgical procedures.

WISCONSIN (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Payment is lesser of customary charges, Medicare limits, or all-inclusive rate per discharge as calculated below; --Allowable base costs updated by inflated index using CPI, WPI, and DRI price forecasts; hospital-specific weights employed wherever possible; adds 1% for intensity; --Input price index adjusted for actual changes in weights and price; --Pass-through costs are: depreciation, interest, rents, malpractice insurance, and fuel and utilities [for FY ending on or after 6/30/83];		Each hospital's total cost divided into fixed/variable cost ratio of 50/50.	
		Blue Cross charge-based payers	Percentage of charges	This separate system adopted an input price index similar to Medicaid's but without hospital-specific weights.			
1982 [Effec. 1/1/82]		Medicaid				Occupancy Instituted target levels for occupancy. Created 4 peer groups by bed size. Hospitals	

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
						below 60th percentile penalized by percentage of excess fixed costs applied to total inpatient expenses [Hospitals with <100 beds exempt].	
1983 [Effec. 7/1/83]	Revised existing Medicaid payment system to include base year cost screens applied to peer group ceilings.	Medicaid		Using first hospital FY ending after March 31, 1981 trended forward to rate year, following 4 distinct reimbursement limits are applied: --Routine Service Cost Limit is set at 104% of peer group mean, using 7 national groupings based on size, location and per capita income; --Average Compensation Per Employee Limit is set at 60th percentile of peer group average, using 10 groupings based on size, location and teaching status; --Employees Per Factored Inpatient Day Limit is set at 60th percentile of peer group average, using same 10 groupings;		Volume Changes Altered fixed/variable ratio to 40/60. Occupancy Limited exemption to hospitals with <50 beds. Inflation Eliminated 1% intensity allowance. Case Mix Adjustment possible on case-by-case basis. Uncompensated Care Exemption from payment limits is provided for 5 hospitals with highest Medicaid volume.	

WISCONSIN (continued)

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
				--Food Costs Per Inpatient Day Limit is set at 60th percentile of peer group mean, using groupings based on size and location; --Guarantees that final payment rates can't be less than previous year solely as result of applying these limits.		These paid prospectively at mutually agreed-upon rates, which can be greater than under state plan. Payment unit remains case per discharge, with interim payments. Following inducements provided: --Reductions in claims processing and reporting requirements; --Exemption from volume adj. within mutually agreed range.	
1984							Requires PRO to achieve 100% pre-admission review for Medicaid elective admissions.
1985 [Effec. 3/1/85]		Blue Cross charge-based payers		Existing budget review/negotiation system revised to require hospitals to submit pre-established fee schedule of 100 charges to show how they will stay within overall revenue limits.			

WYOMING

YEAR	TYPE OF SYSTEM	PAYERS INCLUDED	UNIT OF PAYMENT	RATE CALCULATION	ALLOWABLE COSTS	ADJUSTMENTS	UTILIZATION CONTROLS
1980	Medicare retro-spective cost reimbursement principles.	Medicaid 27 hospitals					
1981							Limit of 14 days per benefit period.
1982	No change						
1983	No change						
1984	No change						
1985	No change						

A Comparative Survey of Medicaid Hospital Reimbursement Systems for Inpatient Services

BIBLIOGRAPHY

General References

"Abstracts of State Legislated Hospital Cost Containment Programs." ORDS, Health Care Financing Administration. HCFA Pub. No. 03089, March 1981.

"A Catalogue of State Medicaid Program Changes 1984-1985." The State Medicaid Information Center, National Governors' Association.

Beyna, L. and Trutko, J. "Exploring the Effect of PPS on Medicaid." Medicaid Program Evaluation Working Paper 8.1. Health Care Financing Administration, October 1984. Unpublished draft.

Bovbjerg, R. and Holahan, J. Medicaid in the Reagan Era: Federal Policy and State Choices. Washington, D.C.: The Urban Institute Press, 1982.

Gaumer, G.; DeMarco, J.; and Coelen, C. "The Performance of Prospective Reimbursement Programs in Hospitals." Cambridge, Mass.: Abt Associates Inc., September 1982.

Hamilton, D.; Walter, R.; Cromwell, J., et al. "First Annual Report of the National Hospital Rate-Setting Study: A Comparative Review of Nine Prospective Rate-Setting Programs." Health Care Financing Grants and Contracts Report. ORDS, Health Care Financing Administration. HCFA Pub. No. 03061, August 1980.

Korda, H. and Koetting, M. "State Medicaid Inpatient Hospital Reimbursement: Summary of State Programs." Medicaid Program Evaluation Working Paper 3.3. Health Care Financing Administration, December 1984. Unpublished draft.

Laudicina, Susan L. Prospective Reimbursement for Hospitals: A Guide for Policymakers. New York: Community Services Society, 1976.

Muse, D. and Sawyer, D. The Medicare and Medicaid Data Book, 1981. ORD, Health Care Financing Administration. HCFA Pub. No. 03128, April 1982.

"Recent and Proposed Changes in State Medicaid Programs: A Fifty State Survey." Compiled by The Intergovernmental Health Policy Project. Washington, D.C.: The George Washington University (May 1981, April 1982, July 1982, April 1983, December 1983, July 1984, December 1984).

"Report on Hospital Prospective Payment Systems Mandated by Section 2173 of Public Law 97-35." ORD, Health Care Financing Administration, October 1982.

Sawyer, D.; Ruther, M.; Pagan-Berlucchi, A.; and Muse, D. The Medicare and Medicaid Data Book, 1983. ORD, Health Care Financing Administration. HCFA Pub. No. 03156, December 1983.

The Status of Major State Policies Affecting Hospital Capital Investment. Intergovernmental Health Policy Project. Washington, D.C.: The George Washington University, April 1984.

Zimmerman, D. DRGs and the Medicaid Program. Intergovernmental Health Policy Project. Washington, D.C.: The George Washington University, June 1984.

_____. State Prospective Payment Systems: New Directions in Hospital Cost-Containment Strategy. Intergovernmental Health Policy Project. Washington, D.C.: The George Washington University, October 1984.

State-Specific References

ALABAMA

"Hospital Reimbursement Program." Chapter 23, State Code of Regulations, Rule 560-X-23.01 through 560-X-23.08, 1984.

ALASKA

"Methods and Standards for Establishing Payment Rates: Inpatient Hospital Care." State Medicaid Plan, Attachment 4.19A (6/77-12/81, 1/82-9/83, and 10/83-present).

ARIZONA

Boland, J. and Reilly, H. "National Hospital Rate-Setting Study, Vol. 1: Case Study of Prospective Reimbursement in Arizona." Health Care Financing Grants and Contracts Report. ORDS, Health Care Financing Administration. HCFA Pub. No. 03029, April 1980.

"Payment for Services: Inpatient Hospital Services." State Medicaid Plan, Attachment 4.19A (5/84-present).

ARKANSAS

"Title XIX Inpatient Hospital Reimbursement Manual." Attachment I, General Policies and Guidelines: Arkansas Medical Assistance Program, July 1984.

CALIFORNIA

"Reasonable Cost of Inpatient Hospital Services." State Medicaid Plan, Attachment 4.19A (7/81-12/81 and 1/82-9/82).

"Description of Methods and Standards Used to Determine Rates for Payment of Hospital Inpatient Services." State Medicaid Plan, Attachment 4.19A (10/82-6/83).

"Approach: Peer Group All-Inclusive Rate per Discharge." State Medicaid Plan, Attachment 4.19A (7/83-6/84 and 7/84-present).

COLORADO

"Methods and Standards for Establishing Prospective Payment Rates--Inpatient Hospital Services." State Medicaid Plan, Attachment 4.19A (10/82-present).

CONNECTICUT

"An Act Establishing a Prospective Payment System for Hospitals." Bill No. 61, General Assembly, State of Connecticut, February 1984.

Gaumer, G.; Summer, M.; and Boland, J. "National Hospital Rate-Setting Study, Vol. II: Case Study of Prospective Reimbursement in Connecticut." Health Care Financing Grants and Contracts Report. ORDS, Health Care Financing Administration. HCFA Pub. No. 03030, April 1980.

FLORIDA

"Florida Title XIX Inpatient Hospital Reimbursement Plan." State Code of Regulations, 1984.

"Health Care Access Act." Chapter 84-35, State of Florida, May 1984.

GEORGIA

"An Alternative Reimbursement System for Georgia Hospitals." Quarterly Report Jan.-March 1981. Department of Medical Assistance, State of Georgia.

"Description of Prospective Case Payment System for Inpatient Services." Appendix C, Sections 1001.1-1001.2, State Code of Regulations (1/83-present).

IDAHO

"Methods for Payment of Reasonable Costs--Inpatient Hospital Services." State Medicaid Plan, Attachment 4.19A (10/79-present).

ILLINOIS

"Methods and Standards for Establishing Payment Rates: Basis for Reimbursement of Hospitals." State Medicaid Plan, Attachment 4.19A (10/81-6/82, 7/82-6/83, 7/83-6/84, and 7/84-present).

IOWA

"Methods and Standards for Establishing Payment Rates--Inpatient Hospital Care." State Medicaid Plan, Attachment 4.19A (10/82-present).

KANSAS

"Medicaid Hospital Prospective Payment System." State Medicaid Plan, Attachment 4.19A (7/83-present).

KENTUCKY

"Title XIX Inpatient Hospital Reimbursement Manual." Sections 100-114. General Policies and Guidelines: Kentucky Medical Assistance Program. January 1985.

LOUISIANA

"Methods and Standards for Establishing Payment Rates--Inpatient Hospital Care." State Medicaid Plan, Attachment 4.19A (7/83-present).

MAINE

"Maine Prospective Reimbursement for Hospitals: Description of Implementation and Current Status." HCFA Working Paper. Division of Program Operations, HCFA Regional Office, Boston. September 1984.

MARYLAND

"Hospital Rate Setting--Maryland's Experience, 1977-1983." Final Report of the Maryland Health Services Cost Review Commission. July 1984.

Worthington, N; Tyson, K.; and Chin, M. "National Hospital Rate-Setting Study, Vol. III: Case Study of Prospective Reimbursement in Maryland." Health Care Financing Grants and Contracts Report. ORDS, Health Care Financing Administration. HCFA Pub. No. 03031. April 1980.

MASSACHUSETTS

"A Background Paper on Chapter 372: The Massachusetts Hospital Cost Control Law." Massachusetts Hospital Association. 1984.

"Questions and Answers on C.372." Massachusetts Hospital Assocition. February 1983.

Weinstein-Walter, R. and Demarco, J. "National Hospital Rate-Setting Study, Vol. IV: Case Study of Prospective Reimbursement in Massachusetts." Health Care Financing Grants and Contracts Report. ORDS, Health Care Financing Administration. HCFA Pub. No. 03032. April 1980.

MICHIGAN

"Diagnosis Related Group (DRG) Prospecitive Reimbursement Program." Medical Assistance Program Bulletin. State of Michigan. Issued 8/84 and 12/84.

"Methods for Payment of Reasonable Costs--Inpatient Hospital Services." State Medicaid Plan, Attachment 4.19A (10/81-12/81, 1/82-9/82, 10/82-3/83, 4/83-9/83, 10/83-12/83, 1/84-9/84, and 10/84-present).

MINNESOTA

Lee, A.J. and Jensen, G. "National Hospital Rate-Setting Study, Vol. V: Case Study of Prospective Reimbursement in Minnesota." Health Care Financing Grants and Contracts Report. ORDS, Health Care Financing Administration. HCFA Pub. No. 03033. April 1980.

"Medicaid Hospital Rate Regulation." State Code of Regulations, Parts 9500.1090 to 9500.1155. State of Minnesota. 1985.

"Methods and Standards for Determining Payment Rate for Inpatient Hospital Services." State Medicaid Plan, Attachment 4.19A (10/83-7/85).

MISSISSIPPI

"Title XIX Inpatient Hospital Reimbursement Plan." State Medicaid Plan, Attachment 4.19A (7/81-6/82, 7/82-6/83, 7/83-9/84, and 10/84-present).

MISSOURI

"Methods and Standards for Establishing Payment Rates--Inpatient Hospital Services Reimbursement Plan." State Medicaid Plan, Attachment 4.19A (10/81-6/82, 7/82-9/83, 10/83-6/84, and 7/84-present).

NEBRASKA

"Methods and Standards for Payment of Inpatient Hospital Services." State Medicaid Plan, Attachment 4.19A (7/82-6/84 and 7/84-present).

NEVADA

"Payment for Inpatient Hospital Services." State Medicaid Plan, Attachment 4.19A (9/83-12/84 and 1/85-present).

NEW JERSEY

Grimaldi, P. "Setting Hospital Payment Rates in New Jersey: A Comparison of the Share and DRG Systems." HRET, New Jersey Hospital Association. 1984.

Worthington, N.; Cromwell, J.; Kamens, G.; and Kanak, J. "National Hospital Rate-Setting Study, Vol. VI: Case Study of Prospective Reimbursement in New Jersey." Health Care Financing Grants and Contracts Report. ORDS, Health Care Financing Administration. HCFA Pub. No. 03034. April 1980.

NEW MEXICO

"Methods and Standards for Establishing Payment Rates--Inpatient Hospital Services." State Medicaid Plan, Attachment 4.19A (12/83-present and new proposal pending approval).

NEW YORK

Hamilton, D. and Kamens, G. "National Hospital Rate-Setting Study, Vol. VII: Case Study of Prospective Reimbursement in New York." Health Care Financing Grants and Contracts Report. ORDS, Health Care Financing Administration. HCFA Pub. No. 03035. April 1980.

"Methods and Standards for Establishing Payment Rates--Inpatient Hospital Care, Part 86-1. State Medicaid Plan, Attachment 4.19A (1/80-12/80, 1/81-12/81, and 1/82-12/82).

"New York's Prospective Hospital Reimbursement Methodology." Office of Health Systems Management, N.Y.S. Department of Health. April 1983.

NORTH CAROLINA

"Hospital Inpatient Reimbursement Plan." State Assurances and Related Information as required by 42 CFR Part 447, subpart C (7/82-6/83 and 7/83-present).

OHIO

"Overview of the Ohio Medicaid Prospective Payment System." Ohio Department of Human Services. September 1984.

OKLAHOMA

"Methods and Standards of Reimbursement for Inpatient Hospital Services." State Medicaid Plan, Attachment 4.19A (11/83-present).

OREGON

"Methods and Standards Used for Payment of Inpatient Medical Hospital Services." State Medicaid Plan, Attachment 4.19A (10/83-present).

Letter from State of Oregon to Associate Regional Administrator of Region X, HCFA, clarifying above-mentioned Attachment. Dated 12/9/83.

PENNSYLVANIA

"Hospitals Under the Prospective Payment System." Subchapter A, Sections 1163.1 to 1163.101. Chapter 1163--Inpatient Hospital Services. State Code of Regulations. July 1984.

RHODE ISLAND

"Rhode Island: Prospective Reimbursement of Hospital Costs." Materials presented by Rhode Island Department of Administration before the Subcommittee on Health of the Committee on Finance, U.S. Senate. June 23, 1982.

TENNESSEE

"Methods and Standards for Establishing Payment Rates for Inpatient Hospital Services." State Medicaid Plan, Attachment 4.19A (10/83-present).

UTAH

"Section 100 Payment Methodology for Inpatient Hospital Services." State Medicaid Plan, Attachment 4.19A (10/84-present).

VIRGINIA

"Methods and Standards for Establishing Payment Rates in Inpatient Hospital Care." State Medicaid Plan, Attachment 4.19A (1/77-6/82 and 7/82-present).

WASHINGTON

Hamilton, D.; Weinstein-Walter, R.; and Lee, A.J. "National Hospital Rate-Setting Study, Vol. VIII: Case Study of Prospective Reimbursement in Washington. Health Care Financing Grants and Contracts Report. ORDS, Health Care Financing Administration. HCFA Pub. No. 03036. April 1980.

"Methods and Standards Used for Establishing Payment Rates for Inpatient Hospital Services." State Medicaid Plan, Attachment 4.19A (7/82-12/82, 12/82-12/84, and 1/85-present).

WISCONSIN

"The Prospective Hospital Reimbursement System: Methods for Payment of Costs." State Medicaid Plan, Attachment 4.19A (7/83-present).

CMS LIBRARY
3 8095 00009151 8